Understanding Munchausen Syndrome by Proxy As Child Abuse

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Dedication

Dedicated to the people, whom I have loved and lost during the writing of this Ph.d

In
Memoriam
Tom Allan
(1926-2007)

DECLARATION

I declare that the research described within this thesis is my own work and that this thesis was composed by my self unless otherwise stated.

The thesis, or part of it, has not been submitted for any other degree or personal qualification.

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Abstract

This thesis will demonstrate how Munchausen Syndrome and, by derivation Munchausen Syndrome by Proxy, grew out of historical themes of assigning disease labels to anomalous or problematic behaviour, replicating issues of gender, particularly in respect of illness and madness and power biases, in society. The literature review will demonstrate how the early case notifications provided 'a Munchausen narrative', which came both to construct and to pathologise, first patients and later women, as mothers. It is argued that psychiatric models account for few cases of child abuse. A more coherent theory allows child abuse and, therefore, Msbp to be understood within a framework, which takes account of past and present ecological influences on the development of individual experience, characteristics and competency, and importantly, the meaning of a child within the life-cycle of that individual.

The research, in this thesis, was designed to provide an estimate of the incidence of Msbp in Scotland. While it confirmed the findings of earlier studies that illness induction and fabrication are rare events, it demonstrated a range of manifestations of abnormal behaviour among parents, in presenting their children to doctors, which were recognisable as being abusive and which often overlapped other forms of child maltreatment and neglect.

It became apparent that the connotations of the title Msbp, particularly in relation to its psychodynamic formulations and evidencing *actual* or a *risk of significant harm*, makes this a professionally fraught and ill-defined area of child protection work for Paediatricians, irrespective of recent Guidance (RCPCH 2002).

The concluding sections of the thesis will consider inherent difficulties in working in this difficult area of child abuse and will provide recommendations for facilitating professional and child protection practices.

CHAPTER I

HISTORICAL REVIEW

This chapter will begin by describing Munchausen Syndrome by Proxy (Msbp) within the context of the historical background and literature of what will broadly be referred to here as Factitious Disorders, which will, in turn, provide a framework for explaining how what is first and foremost a form of child abuse, has come to be classified within a model of adult psychopathology i.e. Factitious Disorder, defined by a very specific motivational component in the perpetrator.

In this model, the motivation to present a child *factitiously* for medical care has historically been classified as a subset of adult Factitious disorders (DSMIV T-R 2000), as a form of inexplicable adult aberrant behaviour, involving a form of attention-seeking: to assume the sick role (DSM IV T-R 2000). Although there may often be considerable overlap in occurrence and type of harm inflicted on a child as an outcome of the physical harm brought about by non-accidental injury and from the sequelae of factitious presentations, in this definition, they are essentially differentiated by the *motivation* of the perpetrator.

In conjunction with a history of shifting terminology, which will be described later, the emphasis on *motivation* has resulted in understandable confusion as to exactly *what* and *to whom* the term applies: whether to the abuse itself, the child as victim or to pre-existing illness in an adult, factitiously seeking medical care for a child to gratify a psychological need for attention. This confusion is recognised and addressed in the Allitt Inquiry (1994): the independent Inquiry set up to look into the events leading up to attacks on children in a hospital in Trent, at the hands of

Beverley Allitt. She was found guilty of four murders and various degrees of serious harm against a further nine children. Unfortunately, the extract below betrays the Inquiry's own lack of clarity.

In an attempt to untangle Munchausen Syndrome from 'Munchausen Syndrome by Proxy' thereby disassociating Allitt's own medical history of self-harming from her crimes, the inquiry commented:

"..... there was little reason to suspect that Allitt was suffering from Munchausen Syndrome before she was appointed to Ward 4. Nor do we find the term Munchausen Syndrome by Proxy helpful in the context of our Inquiry. As we have pointed out, there is a remarkable degree of confusion in the medical literature as to its precise meaning and as to whether it is the victim or the perpetrator that suffers from the syndrome" (p79).

As a result of the Allitt case and in spite of their efforts, it was cemented in the public consciousness thereafter, that MS is a diagnosable *medical* condition, which is a pre-requisite to the same form of harm i.e. illness falsification, except involving a child as victim (Msbp). While there are similarities between Munchausen Syndrome and Munchausen Syndrome by Proxy in that both involve the simulation of illness often to achieve medical attention, not enough is known about them to draw conclusions about how similar they are in motivation (Parnell and Day 1998).

For example, Rosenberg (1987) estimated that between 10-25% of mothers faking illness in children, did so in themselves. Perpetrators have been noted as manifesting signs of MS preceding Msbp abuse or, subsequently, once confronted (Schreier and Libow 1993) or, almost in relay (Waller 1983, Sigal, Gelkopf and Meadow 1989) on occasion, involving more than one child and the mother herself presenting at various stages as ill. However, it is likely that the motivation to self-present with falsified simulated illness is different from presenting a child. This more than likely relates to a pathology in the mother-child relationship rather than

the motivation to present as sick, as well as the level of attention provided to mothers of sick children in paediatric settings.

The construction of Mbp on an axis from Adult Factitious Disorders established and maintains the idea of illness and disorder in the adult perpetrator and has essentially restricted the context to medical health care settings. It is suggested here, firstly, that this might be a reductionist interpretation of this form of abuse and secondly that the fabrication and misrepresentation of children's needs might occur in other contexts and perhaps contemporaneously. A child might conceivably be presented as, for example, ill to a health care setting and as having a behavioural disorder or developmental disorder to a child psychologist. This view is argued, elsewhere. (Schreier 1996). Schreier, who has advanced psychodynamic interpretations of Msbp has argued for including cases involving fabrications to other care services e.g. psychologists or '*professionals occupying (perceived) positions of power*' e.g. fire brigades, sheriffs, with *motivations* other than *to assume the sick role.*

There is some evidence from cross-cultural studies that western-style medical care systems actively engender Msbp abuse and it is by providing a context for it to occur that this happens.

Rosenberg's (1987) epidemiological survey indicated that 70% of the cases she reviewed, took place in hospitals, leading her to conclude that hospitalising a child when there is no suspicion of Msbp, increases the potential risk. However, she recognises that when a diagnosis is suspected, hospital may be the only place to make it firm.

In an examination of the Msbp medical literature, Feldman and Brown (2002) identified 59 articles from 24 countries describing 122 cases in 9 languages. They concluded that cases were *more likely* to occur or *go undetected* in countries, which had come to place less importance on good history-taking in favour of modern

western approaches to the diagnosis of illness, with its greater emphasis on technology and testing. However, present day approaches to diagnosis now re-emphasise the importance of establishing the case history and background before intervention. (Eminson and Postlethwaite 2000).

Feldman and Brown's (2002) survey has also provided good evidence that some perpetrators seize opportunities to abuse children in contexts, in which the apparatus of care, attention and the drive to problem solve and offer help kick in fairly quickly, as often may be the case in paediatric medicine. Although some mother-perpetrators believe their own stories (Fisher et al 1993) and some may be actively delusional about their child's health (Woollcott et al 1982) there are also those, who when questioned, demonstrate very clear intentionality and planning (Parnell and Day 1998).

Evidence for this opportunistic dimension, provided by medical settings, is further provided by Feldman and Brown's research. They noted that reported presentations of Msbp remain fairly consistent across the literature surveyed, in terms of demographic details and the principal methods of falsifying or producing illness. The notable exception is that of induced apnoea, which although one of the commonest forms of Msbp abuse in the US and GB, was '*infrequent*' in the literature, which they surveyed. While this might relate to poor identification and differentiation of induced apnoea from SIDS due to lack of awareness and skill (as well as forensic support), it also suggests that western mothers 'sensitised' to the widespread use of apnoea monitors, paradoxically utilise this. They may literally know which buttons to press to bring about a panic effect in staff working in hospital baby-units. This has been caught on video-tape (Southall et al 1997).

Although it is beyond question that falsifying illness in a child can potentially have dangerous immediate or long-term consequences, with high levels of actual and potential morbidity, both physically and psychologically (Rosenberg 1987), it is

suggested here that presenting children falsely in *any* context can have a range of equally damaging consequences, particularly if the child *accommodates* to the mothers projected image and colludes with her construction of him or her as ill, when actually well or as having other specific difficulties e.g. learning difficulties or as being the victim of abuse etc.

However, arguments in favour of broadening the definition of what can broadly be termed *falsified presentations*, particularly beyond medical settings has its opponents (Jones 1996 Eminson and Postlethwaite 2000). Jones in particular, expresses concerns that extending the label Msbp to other contexts might result in the 'dilution' of the level of risk in the mind of Paediatricians and, presumably other professionals. Maintaining such a narrowly circumscribed definition of motivation to simulate illness, to bring contact with the medical profession, actively *excludes* other professional groups from articulating similar patterns of abuse to a child but in different contexts of the child's life. That Msbp can only be diagnosed by experts in the medical field is endorsed elsewhere (Meadow 1985, Rosenbeg 1987).

At the core of this debate is the fraught issue of *motivation* to abuse defining the abuse itself, which is essentially the medical stand-point. This causes confusion and confounds child protection work, as professionals fluctuate somewhere between ignorance and fear. It will be argued here that it is more useful and serves the needs of children more effectively, if any manifestation of abuse involving *simulation* of illness or any other form of misrepresentation of the child, for example, as being autistic is defined within the parameters of the concept of *Significant Harm* (SWD Children (Scotland) Act 1995), which offers a focus on the meaning and implications of the abuse to the child, with no reference to the motivation of the perpetrator. Psychiatric labels relating to motivation etc. are only of use in child protection work in as much as they are able to inform present and future levels of work to the child/ren within the family, subsequent to the identification and acceptance that the abuse has taken place, in the first place.

Although Eminson and Postlethwaite (2000) take a similar view to Jones in respect of *not* broadening definitions and motivations, they recognise likewise that motivation *per se* may have scant relevance in assessing the present and past behaviour of the perpetrator. In this respect, it is actually more significant that the abuse has been acknowledged by the perpetrator.

The use of terminology will be discussed later but undoubtedly the contemporary emphasis on dropping references both to Munchausen and the concept of Syndrome, in favour of labels, which are more descriptive of the dissembling aspect of perpetrator behaviour, and which do not carry the same connotation of adult psychopathology, as does Munchausen, *demystifies* this form of child abuse and allows the focus to remain on the child as victim.

Although *Fabricated or Induced Illness* by Carers (Royal College of Paediatrics and Child Health 2002) is the preferred terminology, in current professional parlance, paradoxically, *Munchausen Syndrome by Proxy* (Msbp) is the most widely recognised and, for that reason alone will be used continuously throughout this thesis. For clarity, therefore and in summary, *Msbp is used here in reference to child abuse and not a disorder in the adult perpetrator.*

It is also argued, hereafter, that Msbp is better interpreted within sociological systemic models of family functioning, with a range of motivations not bound to one particular context. The historical origins of Msbp offer some insight into how a manifestation of child abuse has become so complex and entwined with models of adult psychopathology.

The following sections will summarise historical attempts to account for Factitious Illness through the literature on *hysteria* and will attempt to demonstrate how

abnormal behaviour becomes constructed and classified into models of mental illness. The taxonomies, which began to emerge, particularly in the 19th century were in effect, the forerunners to the modern diagnostic approach, as provided now by the psychiatric DSM and clinical ICD classification systems. It is useful to set the construction of Factitious Disorders from which MS and Msbp emerged against this back-cloth of historical precedent of defining particular sets of troublesome or anomalous behaviours as illness or disease. These tended to mirror contemporary power bases and biases.

Historical Background To Factitious Illness: The Emergence of Mental Illness

Deliberately presenting factitiously as ill to Doctors has an extensive historical pedigree and is not a phenomenon of modern times or hospital systems. There are likewise a recognised range of purposes *motivating* this behaviour – some of them perhaps more understandable to a modern reader. For example, the pejorative term *malingerer* (Fr.malingre: sickly) was a term first used to describe soldiers attempting to avoid forced conscription into the army, during the Napoleonic Wars. In modern-times, fraudulent claims for sickness benefit were made from the time they became available (Taylor 2000). Currently, Doctors are familiar with falsified illnesses to obtain drugs. Consciously or unconsciously, Doctors have historically been pulled into the public performance of being ill for gain. (Taylor 2000).

Throughout the 19th and 20th centuries until the advent of the work of Laing (1962) and Szasz (1974) and the anti-psychiatry movement, which essentially reconstructed mental illness within sociological models rather than predominantly within models of illness or psychopathology, attempts in the early psychiatric medical literature to account for factitious or 'hysterical illnesses', which had no foundation in organic disease, encoded and reflected contemporary social biases and structures and the necessity of maintaining social order and equilibrium. (Allison and Roberts 1998).

So, for example, a survey of the historical literature of Factitious Disorders uncovers both practical preoccupations with detecting fraudulent illness in military and naval contexts, coinciding with early works which represent genuine attempts to explain psychological illness e.g. *hysteria*; which from classical times (Hippocrates and Galen) through to the Victorian period, has been constructed, essentially as a female condition. The *humoural* view of hysteria as being sited in the womb (GK *Hystera*), remarkably persisted until the 19th century and contributed to the view of women as being the weaker sex, emotionally and, by extension, established a way of perceiving women which had implications for them in Victorian society and beyond. This cultural tradition saw women associated with nature and body and men with reason, discourse and mind (Showalter 1985). This gave rise to a fundamental alliance and cultural association between women and madness in science and Art.

For practical reasons, when Gavin (1838) produced his prize-winning essay to the then Professor of Military History at Edinburgh University, the punitive measures which he advised for uncovering "impostors" were aimed at the retention of conscripts and the maintenance of order in the forces. There is little hint in Gavin's work of any clinical judgement or differentiation of those, who might be genuinely ill nor is there compassionate understanding of why they might not wish to remain in military service. Ideas about *nervous breakdowns*, in battle, emerged only in the 20th century although concussion arising from explosions or other external factors is recorded as early as 1541 (Merskey 1991). Military stress disorders came only to be formally recognised in 1980 (DSM III) as a result of the Vietnam War.

Although Gavin was essentially ahead of his time in attempting to classify factitious presentations, (he identified 70 'forged or factitious *diseases*'), the context of his work precluded any real analysis of the cases he and other Doctors might have been presented with, even if he had had the will to do so. His work contributed to the maintenance of social control and retention, predominantly of working class

conscripts, who wished otherwise just as Cartwright's work had achieved in 1850's Louisiana, in respect of absconding slaves, a condition he medicalised and labelled *drapetomania (Gk Drapetes)*. Just as there were ridiculous *cures* for hysterical women e.g. marriage, which reflected the social and moral framework of Victorian Britain, so did Cartwright suggest punitive sanctions for maintaining the slave work-force, as Gavin before him had done for the military (Allison and Roberts 1998).

Unlike Gavin, whose Handbook offered to detect and expose '*shirkers and malingerers*' in the navy and military, there are genuine attempts to categorise and describe *hysteria* and *hypochondriacal presentations* to be found, albeit constructed within a very specific cultural context. This literature is characterised by the search for an organic basis for what in modern terminology would be broadly referred to as *mental illness.*

The English Malady, Cheyne (1737) (in Allison and Roberts 1998) documented the range of hypochondriacal and factitious presentations to be found among the *genteel* classes of England, particularly among its women. Carter (1853) advanced a taxonomy which described his patients as presenting as ill, due to feelings of emotional neglect, through to actual simulation of illness and symptoms. In many ways, Carter's work 'On the Pathology And Treatment of Hysteria' (1853) anticipated Freud's concept of the unconscious and *drives* and, in turn that of Menninger (1934), who first described 'poly-surgical addiction' and it is argued Asher's (1951) first clinical description of what he referred to as 'Munchausen's Syndrome' and Meadow's (1977) description of 'Munchausen Syndrome by Proxy'. While Carter may have been misguided in describing *hysteria* as a unitary illness, he at least attempted to offer explanations for the presentations he saw based on psychological need and motivation. Remarkably, this emphasis is lost to Asher (1951) when he comes to describe Munchausen Syndrome (1951).

Subsequent theorising about the origins of hysteria can be tracked through the work of Brodie (C1837) through to Charcot (C1870) to Freud in the early 20th century. Unlike Gavin (1838), who was motivated to establish for very practical reasons, the factitious and fraudulent aspects of illness in the military, Brodie and Charcot were persuaded that anomalous psychosomatic symptoms were to be differentiated from purposeful and fraudulent presentations. They both effectively provided *hysteria* with the medical status of illness. Brodie argued that what he referred to as 'hysterical affections' lay within the control or 'volition' of the patient to act differently. Nonetheless, he believed that the symptoms and conditions, which he saw in his orthopaedic practice, merited treatment and sympathy, being *real* to the patient although without organic basis. In modern terminology, these would correspond to the broad category of *Somatoform Disorders* (DSM IV T-R 2000) in which disorders involving physical symptoms are not fully explained by any 'psychological disorder'.

It was however Charcot, who provided the conceptual shift, which constructed the same pattern of presentations of anomalous psycho-somatic symptoms as actual disorders. He disputed Brodie's idea of the 'volitional' aspect of anomalous psycho-somatic symptoms and advanced his own interpretation of them as being *real* conditions, even in the absence of an organic basis. What Brodie had earlier defined as 'ideation', Charcot defined as 'disorder'(Allison and Roberts 1998). Charcot effectively established the concept of mental illness although it was not until Freud provided his structural theory of the unconscious that the bridge between psyche and soma was constructed. Freudian theory offered psychical explanations for non-organic psycho-somatic *illness* presentations. In Freud's model, the patient has limited conscious volition but is governed by the unconscious. Any symptom, even if it could not be established clinically as 'disease' is a valid symptom of a psychoneurotic disorder. Freud, of course, believed that the role of the psychoanalyst was to unblock the unconscious to the patient. (Allison and Roberts 1998).

Crucially, throughout this period from Charcot to Freud and beyond, a broad spectrum of human behaviours and emotional states become classified and understood within medical disease models with no basis in organic disease. Themes of mental illness naturally evolve as does psychiatry as a discipline.

The Emergence of Classification Systems

Just as the industrial classes provided traumatised subjects for Charcot, academic psychiatry was given a boost subsequent to the 1st world not only with a plentiful supply of soldiers presenting with *shell-shock* and various forms of anxiety disorder but with the emergence of diagnostic manuals and classification systems. Diseases were either psychical or somatic as were their treatments and were eventually *defined into existence* through the medical classification system (Allison and Roberts 1998). During this period, psychodynamic themes and therapies held sway, influencing other branches of medicine.

The first of these was the *Statistical Manual For The Use Of Institutions For The Insane*, produced in 1918. Its 10 revisions very much reflected the biases of hospital based psychiatrists and, as in the later DSM (1952) classification system, reflected clinical practice in work with hospitalised soldiers after the Second World War.

Much of the criticism of the early Manuals, some of it contemporary, was levelled at the lack of empirical data relating to aetiology, prognosis or treatment of the illnesses to substantiate the decisions taken for describing certain behaviours as mental illness. By the time of DSM II in 1968, an array of behaviours were added to the list of mental illnesses. Many were highly questionable and were the results of conflicting and vested socio political interests, not to mention '*bad science*'. This is best exemplified in the classification of homosexuality in both DSM I and II,

reflecting the influence of Freud's theoretical psychoanalytical perspective (1923) on unresolved sexuality in males: *Oedipus Complex*. However controversy surrounding the inclusion of homosexuality prompted a definition of mental illness - 'disorder' - from Spitzer, an American Psychiatric Association panel member and a major compiler of the DSM II. He eventually took the view that mental disorder was to be *'defined as a behaviour accompanied by subjective distress or a general impairment of social effectiveness or functioning. Since some gays .... "did not suffer from subjective distress .... They could not be considered mentally ill" (1968).* This episode demonstrates the arbitrary nature of the classification systems and how easily a group or particular behavioural presentation can become assigned to a medical diagnostic category, which might ultimately be employed for purposes of policing and control.

Criticism of how *mental illness* had come to be constructed and criticism of Psychiatry itself came from R.D. Laing (1962), a Scottish Psychiatrist who challenged the whole premise of mental illness, as it had evolved in the first half of the 20th century. In short hand, he described mental illness as a metaphor for describing the breakdown between self and others, resulting in the emergence of a *'schizophrenic self'*. He challenged the idea that behaviour can ever be construed or categorised as *disease* or *illness*. He advanced more dynamic explanations of behaviour and psychological stress/anxiety as rooted in the individuals experience of the family and society rather than rooted in unconscious 'drives', apart from those processes and structures suggested by Freudian theory.

Szasz (1970, 1974) repeated and extended, considerably, Laing's criticism. In The Manufacture Of Madness' (1970) and in The Myth of Mental Illness (1974) he criticised the theoretical perspectives under-pinning professional psychiatry and the whole conceptualisation of mental illness in the absence of organic origins causing it. He took the view that if there is no disease then there is nothing to treat. Like Laing (1962) Szasz was infuriated by political issues around the abuse of personal

freedom and societal paternalism and the powers ascribed to psychiatrists, who colluded with this.

Szasz (1970, 1974) questioned the processes, which ultimately produced what he referred to as *'a homogeneous scheme of diseases'*, which effectively justified itself. In this model, illness is either physical or psychological in origin. Intervention to treat or change implies not only that they should be changed but that Psychiatrists, as opposed to any other profession, are the people to do this. By extension, the medical classification systems enshrined in the Diagnostic And Statistical Manuals (DSMI – DSM IV R-T 2000) provides the framework to substantiate and validate psychiatric practice by classifying behaviours, better dealt with within psychological and sociological frameworks as *illness*, *disease* or *disorder*. This process is reiterated in the modern conceptualisation of Munchausen Syndrome by Proxy. Laing would have argued that even should organic causes be identified e.g. in certain manifestations of Schizophrenia or Depression, what is observed or reported as *disfunction* or *apparent disfunction* becomes constructed as a problem for society or the individual, as defined by the historical context within which it manifests itself. It is difficult to argue that it could be otherwise: however, although they did not share the same political and theoretical perspective, the issue both for Laing and Szasz is the construction of *incongruent* behaviour within medical models rather than within broader ecological contexts.

Whatever view is taken of Laing's (1964) and Szasz' (1974) attack on the fundamental authority and premise of psychiatry via challenges to the very construction of mental illness, they prompted debate about bio-medical models as offering *pure* explanations for *psychopathology,* which itself was called into question. In an extremely influential text, 'Critical Psychiatry: The Politics of Mental Health', Ingleby (1980) argued for exactly that- *critical* thinking about the conceptual foundations of psychiatry and for a debate about issues of professional

power in respect of *diagnosis* (with its ramifications), which troubled Laing (1964), in particular.

More recently, and deliberately paralleling the title and theme of Ingleby's work, Double has brought these issues into the present. In his conclusion to 'Critical Psychiatry: The Limits of Madness' (2006), he argues that it is *logically unassailable* that since all thought and behaviour have their origin in the brain that brain pathology explains mental illness. To this extent '*the biological dimension cannot be denied*' (p225). He does, however, acknowledge that the biomedical hypothesis offers a reductionist interpretation of the relationship between brain and mind. His final statement that '*minds are enabled but not reducible to brains*' (p225) provides some hope of, *if not* a paradigm shift, then at least the potential for more comprehensive evaluation of behaviour (sic mental illness) taking in all of the scaffolding factors affecting individuals, psychologically.

However, it is argued that explanations of behaviour, provided by the bio-medical model persist. Such is the continuing level of willing acceptance and expectation of medical labels to describe an increasing range and types of behavioural presentations that it has become difficult in practice to offer different frameworks of analysis to account for behaviour: for example, a systemic approach such as family therapy. Just as early theorisers did for *Hysteria*, contemporary clinicians continue to offer linguistic constructions to describe behaviour using illness metaphors such as 'syndrome' or 'disorder'. The down-side to this is that medical labels, which carry a high tariff, can confound intervention work, with individuals and families to achieve change, acting often as a diversion, which is difficult to shift.

This trend is currently well exemplified in the medicalisation of children presented to psychologists and Child and Family Psychiatry teams with behavioural and management difficulties. Labels such as Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiance Disorder (O.D.D) or Conduct Disorder (C.D)

emphasise *within* child factors and often provide a *diversion* away from more salient systemic and ecological risk factors in the child's life, which are implicated or central to the origin and sustaining of the behaviour. When ADHD is *diagnosed* – usually by a Psychiatrist and clinical team – the application of science in the form of medication (Ritalin, when prescribed) affirms the *diagnosis* and authenticates the label, thereafter. Even in the absence of success with Ritalin, which is more often than not the case, it is difficult to shift the *diagnosis*, which had provided the hope of a quicker 'fix' than longer term systemic family work. Access to the internet now permits home-diagnosis, by parents, who match their child's behaviour to broadly defined criteria. This can produce fearful adversaries when attempting to offer alternative interpretations of a child's behaviour, particularly if embedded in issues of wider family functioning rather than *within* the child.

Finally, the problematic nature of medicalised behavioural labels are given ultimate, current expression in the controversy surrounding *Anti-social Personality Disorder*, particularly in prison and, indeed, within non-prison populations. At the centre of debate is the loophole-issue of *treatability* and whether people labelled with technically *untreatable* conditions should be detained under the Mental Health Act – if they would not benefit from being detained in the first place. In a move to plug this loophole, particularly in respect of patients in State Mental Hospitals, who might successfully legally challenge their detention, the Government White Paper (2000) introduced the category 'Dangerous Persons with Severe Personality Disorder (DPSPD), which effectively extended the committal criteria to include '*any disability or disorder of mind or brain, which results in an impairment or disturbance of mental function*' (Part I Section 2(6)). This purposefully links Personality Disorder to dangerousness (Appelbaum 2005) to justify detention.

The concept of treatability was retained in the 2004 Government Draft White Paper but broadened to incorporate those people requiring support from a wider range of

professional services in the community other than psychiatry or hospital based services.

In an article in which he described 'England's' experiment in using psychiatry for public protection, Appelbaum (2005) describes this as effectively opening the door to anyone being committed and detained.

SUMMARY

The purpose in providing this necessarily brief historical synopsis has been to offer an historical context as well as conceptual framework, from which it is argued Munchausen Syndrome and, by definition, Munchausen Syndrome by Proxy, naturally emerged. To this purpose, the processes and practical influences, which has seen medical diagnostic models applied to describe and by implication, account for an ever-increasing range of human behaviour and actions, have been highlighted.

Implicit in a model emphasising illness or disorder is the centrality and role of Doctors not only in classifying behaviour as such but invariably, thereafter, as being significant in changing (treating), controlling and policing behaviour; a concern, which prompted Szasz' critique of psychiatry (1974). The statutory role of psychiatrists in the assessment of patients also ascribes them powers to detain and/or to recommend long-term incarceration, paradoxically in state *hospitals*. The irony of this has not escaped this group of patients (or their legal representatives), who have successfully challenged their own incarceration based on the treatability issue of *Personality Disorders.*

In their defence; Psychiatrists have raised objections to the very worrying proposals in the recent Government Draft Paper, in respect of DPSPD (Appelbaum 2005). However, it has come too late in the day. The processes, which define behaviour as illness, by implication, enshrine the position of the profession deemed as having the

necessary skills to diagnose the *illness*, even when there technically might often be none. Having a position defined as pivotal, by legislation, effectively partly *constructs* that profession and makes it difficult for it to extricate itself or behave in a manner approaching professional independence. The abuse of medicine and psychiatry, in particular, in totalitarian regimes such as Russia, during the height of The Cold War provides a case in point, albeit an extreme one. Psychiatry was utilised to justify the control and imprisonment of political prisoners, who, supposedly legitimately diagnosed as *mentally ill,* could, by these means, be effectively put away.

It is suggested that the processes and preoccupations, which have been described here are applicable to the emergence and construction of Munchausen Syndrome but more especially to Munchausen Syndrome by Proxy. These antecedent historical processes provide some explanation of how a form of child abuse comes to be constructed on an axis from adult Factitious Disorders and how Msbp came to be constructed as aberrant maternal behaviour as opposed to simply being defined as another manifestation of child abuse. Motz (2001) has argued that women's behaviour is more often medicalised and explained through medical models than are male counterparts. This diverts from the recognition of women's capacity to be violent and to harm children (and often themselves) (Motz 2001). The pivotal role of Doctors is also a key aspect of MS and Msbp, both in terms of providing the context of the definition but likewise in inadvertently sustaining the behaviour, at its most serious and life-threatening, in hospital settings: This will be more fully addressed in the section on *motivation.*

The Modern Construction of Msbp

Although this section will concern itself with Asher's 1951 and Meadow's 1977 papers, any consideration of the antecedents of Factitious Disorders, of Munchausen Syndrome and Munchausen Syndrome by Proxy should come via Menninger's 1934 description of 'poly-surgical addiction'. Menninger was heavily influenced by

Freudian psychodynamic theory and his theory of neurosis as it manifested in psycho-somatic presentations to Doctors. Freud's contribution of unconscious drives operationalised existing medical theories about the volitional nature of factitious disorders.

Freud modified his theories frequently across several decades in to the 20th century. Simply put, he described 'flight into illness' as offering relief (*gain*) from the stress caused by wider anxiety disorders. The symptom, therefore, provided *diversion*. *'Conversion'*, which is central to this theory describes the transmutation of psychic symptoms into *illness*. Freud's more controversial theories of unresolved sexual drives and of *transference* influenced Menninger's interpretation of patients, whom he saw in his practice, demanding surgery.

In keeping with Freud's theoretical perspective, Menninger (1934) interpreted his patient's demands to represent the unconscious seeking of a relationship with the surgeon as a powerful male figure; in effect a father transference. In the arena of the operating room, the surgeon becomes the source of a range of opposed state; love/hate, pain/pleasure, origin/finality (Allison and Roberts 1998). In this model the patient is willing to make physical sacrifices (unnecessary treatment) to achieve unity with the Doctor. This will be echoed later in interpretations of *motivation* in Msbp.

Menninger (1934) hypothesised four unconscious motives prompting demands for unnecessary surgery all framed by psychodynamic theory. The influence of Freud is therefore strikingly obvious: (1) to avoid a greater fear than surgery (2) the need for a father transference to a strong, dynamic surgeon (3) an ungratified infantile wish (both sexes) for a child and (4) the desire/wish to be castrated (both sexes). Few people – particularly surgeons - would now accept Menninger's adoption of virtually the totality of Freudian theory as an explanation for 'poly-surgical addiction' (Allison and Roberts 1998). However, a number of major writers, subsequently, have undoubtedly run with the same *theoretical ball*: Cramer (1971), in respect of

Munchausen Syndrome and Schreier (1992), who as one of the most influential writers after Meadow, has advanced psychodynamic interpretations of Msbp, which persist.

Schreier alone (1992) and in collaboration with Judith Libow (1993), who has contributed a broader sociological component to their work, has employed Freud's concept of *transference* (to a perceived powerful male figure) to account for the motivation of women-predominantly – to present their children falsely, *by proxy*, to Doctors for treatment but also to explain how Doctors in the first place, came to be integrated into the core of the disorder.

Schreier, however, does not restrict his model to medicine but extends this to other professional groups (1996). In collaboration with Judith Libow, they produced 'Hurting for Love' (1993). After Meadow's own 1977 paper, this text has been extremely influential in the construction of Msbp, particularly in its profile of Msbp perpetrators. They identified three main groups of mother-perpetrator: active inducers, Doctor-addicts and help-seekers, in an attempt to categorise presentations to Doctors.

Munchausen's Critics

At a more fundamental level, a number of writers have mounted major critiques of MS and by extension Msbp arguing that their original formulation and, therefore, validity as constructs are fundamentally flawed (Allison and Roberts 1998) Mart (2002). This aspect will be developed more fully in a separate section but it is useful to take time aside, at this stage in the historical review, to highlight the main critical themes.

In an important text, which effectively dismantles MS and by extension Msbp and whose title is noted here, in full, as being self-explanatory: "Disordered Mother or

Disordered Diagnosis? Munchausen by Proxy Syndrome. Allison and Roberts (1998) are critical of the medical-historical tradition, particularly in psychiatry, of descriptive diagnostic labelling, from which, they argue, MS emerged. They argue also, as does Mart (2002) that MS subsequent to Asher's 1951 paper, was validated essentially through the ensuing medical correspondence in the Journals (some of which is reviewed here). As will be explained below, the Doctors, who rallied to Asher's (1951) call for papers, did so enthusiastically but uncritically: most correspondents being only too willing to latch on to Asher's descriptions of patients, whom they recognised as problematic people and, diagnostically confounding.

The greatest all round significance of Asher's (1951) paper is the use it makes of medical terminology *sic* 'syndrome' to describe what are essentially the behavioural characteristics of adults presenting with factitious disorders. This is problematic. Not only does it represent as Cunnien (1997) puts it, the *medicalisation* of illegal behaviour but from the stand-point of any technical definition of *syndrome,* is questionable. The three cases offered by Asher (1951) to illustrate his own theory, would not meet the established medical definition of 'syndrome' (Allison and Roberts, 1998, Mart 2002). Above all, the connotations of *syndrome* provide explanations for child abuse rooted in (adult) illness rather than more appropriately in behaviour, which is volitional and intentional. The volitional aspect of adult behaviour, which permeates the historical debate about factitious sic psycho-somatic/hysterical illness is extrapolated to describe the motivation to present children factitiously (*by proxy*) as ill.

Finally, issues have been raised in respect of single observer inferences and culturally constructed bias (Allison and Roberts 1998) in Asher's paper, in particular but clearly this applies to subsequent case-reporting (Chapman (1957), Clark and Melnick (1958).

Asher's Paper to The Lancet (1951): The Emergence of Munchausen Syndrome

Asher's (1951) paper to The Lancet 'Munchausen's Syndrome' published in a section 'Special Articles' established the name *Munchausen* to describe adult factitious somatic presentations to Doctors. Taking the name of the famous 18th century baron, Asher was drawing parallels with his legend as a confabulist, who told exaggerated tales of his travels and other exploits – but apparently not about his health. Taylor (1992) has criticised Asher's association of adult factitious presentations with the comic figure of the Baron, arguing that it underestimates the harm to self and others not to mention the waste of time and resources, which factitious presentations often result in.

As a general comment, Asher's paper is remarkable as much for what it is as for what it is not. Although it provides the origin of MS and therefore Msbp, had Meadow not adopted the factitious illness metaphor to describe the abuse of children (Msbp 1977) by similar acts of falsification in health care settings, it is questionable that it would have achieved the significance it has. As it is, the two papers (1951, 1977) are inextricably linked and together provide for the juxta-positioning of adult psychiatric disorder (Munchausen Syndrome) and a form of child abuse (Munchausen Syndrome by Proxy). However, Asher's original conceptualisation of the behaviours, which he observed as constituting a medical syndrome *sic illness* has proved to be consistently problematic.

Meadows (1977) paper brought together the psychiatric (MS) and paediatric (Msbp) strands, but without a clear rationale as to how the two are linked (Eminson and Postlethwaite 2000), although this has evolved over time. This has generated issues of confusion, which persist as to what Msbp is and to whom it refers. More significantly, the term Munchausen (Syndrome) by proxy has been generally understood to imply pre-existing adult psychopathology. Difficulties in

interpretation have been compounded by changes in terminology, sometimes inconsistently, to lose the connotations of 'Munchausen'. Issues in respect of pre-existing adult illness and motivation compound confusion.

It is considered worthwhile examining Asher's (1951) paper in detail, providing as it does the *locus classicus* to which reference has to be made. It will become apparent from the analysis of the paper that it does not meet the requirements for a medical paper and has been criticised for this. (Allison and Roberts 1998). That he made the contribution of a medical syndrome owes more to the Doctors, who were willing to accept his categorisation of a group of nuisance patients, once Asher (1951) established the behavioural *profile*.

The medical literature subsequent to Asher's (1951) paper uncritically validated his original premise that the behavioural characteristics of a specific group of patients constituted a syndrome. It is suggested here that the *syndrome aspect* was incidental to the readers of Asher's paper. The style and content of the 1951 paper appealed more to those Doctors, whose sense of being annoyed and duped by the concurrence of signs and behaviours, which constituted 'Munchausen' presentations, caused them to suspend both their critical and diagnostic judgement.

There are likewise inherent difficulties in Asher's use of the term *syndrome* depending on whether it is used *diagnostically*, as in medicine to describe a range of symptoms or signs, which may or may not relate to an underlying cause and illness or *descriptively* and *explanatory* as used in the behavioural sciences to describe *outcomes* of illegal behaviour (Mart 2002). By way of example: medically a female child presenting with learning difficulties, specific physical characteristics and a genetic profile showing a micro deletion on chromosome 7q11.23 will meet the criteria for '*Williams Syndrome*'. In contrast, '*battered women syndrome*' or *Child Sexual Abuse Accommodation Syndrome* (Summit 1983) are employed to describe the psychological outcomes of abuse: for example, to describe respectively why a

women stays in an abusive relationship and why a child fails to disclose abuse. Neither 'syndrome' can be used diagnostically to determine abuse or not as do medical criteria for disease syndromes. The modern use of *syndrome* now seems fairly arbitrary, offering to describe illness, disorder or the outcomes from illegal behaviour (Mart 2002).

The same confusion is apparent in how MS became Msbp and why there is confusion as to how on the one hand, one set of behaviours is labelled as an illness/syndrome (MS) and another as criminal behaviour (Msbp). As argued throughout, applying medical illness labels to describe or, more importantly account for anomalous or problematic behaviour, creates more difficulties than it resolves. When Asher (1951) utilizes the term 'syndrome' to describe the behavioural characteristics of patients presenting with factitious somatic complaints, he is emulating the established trend described above of descriptive diagnostic labelling favoured by Psychiatrists (Eminson and Postlethwaite 2000). That he refers early on in his paper to 'diagnosis' makes this even more apparent.

Asher's paper is as much as empathic sharing of concerns with colleagues, who have been victims of the Munchausen deceit – "*few Doctors can boast they have not been hoodwinked by the condition*" (p339) as it is a clinical description of a disorder or syndrome. His intention was clearly also to alert Doctors to specific patients as well as a patient-type. Referring to the case-studies of Thomas Beeches, Margaret Coke and Elsie de Coverley he notes he has changed their names although they were likely to have been false to begin with; '*but Doctors, who have met any of the patients may find that the changed name gives a clue to the original one' (p340). Later, in his conclusion he adds, 'If any correspondence follows this account, exposing other cases, perhaps some good will have come' (p341).* (Allison and Roberts 1998).

The theme of surveillance permeates the paper to the extent that front-gate porters are recommended as first or front-line diagnosticians. In a remarkable observation,

which justifies Allison and Roberts (1998) concern that Asher's paper is among other things not a medical one, he states: *'Usually the patient seems seriously ill and is admitted unless someone, who has seen him before is there to expose his past. Experienced front-gate porters are often invaluable at doing this' (p339).*

While it needs to be acknowledged that factitious presentations will carry a high frustration tariff in a busy hospital setting, Asher's concern as a Psychiatrist might more appropriately have lain with offering an explanation for the behaviour, which he describes as 'a psychological kink' rather than offering mechanisms for policing patients.

From the first line of his paper, Asher establishes the concept of *syndrome*, drawing on Doctors' experience of factitious presentations to affirm the reality of *Munchausen's Syndrome: "Here is described a common syndrome, which most Doctors have seen"* (p339). His use of anecdote and humour help establish a professional camaraderie in the recognition of the behavioural characteristics of 'a patient type', which he later elaborates in the three case vignettes referred to above:

'Often the diagnosis is made by a passing Doctor or sister, who, recognising the patient and his performance exclaims: "I know that man. We had him in St Quinidine's two years ago and thought he had a perforated ulcer" (p339) and,

'Equally often, the trickster is first revealed in the dining-room, when, with a burst of laughter, one of the older residents exclaims: " Good heavens, you haven't got Luella Priskins in, again, Surely " (p339)

The thread, which is woven throughout the paper is of a medical syndrome characterised by persistence and duplicity. *Patients* are constructed primarily from the perspective of Doctors being troubled by this behaviour.(Allison and Roberts 1998). While Asher recognises that patients may be ill, his emphasis remains on the falsehood accompanying the presentations, which for him, define the syndrome. It was the elements of duplicity and falsehood complicating diagnosis, which Doctors

responding to Asher's request for correspondence, recognised and acknowledged. They also accepted unquestioningly, however, the concept of there being a separate *syndrome.*

Asher's paper is punctuated by his own affirmatory references to *syndrome*, which is a term he uses consistently and diagnostically, even although in the true sense of the medical use of syndrome, the behavioural signs exhibited by patients could not be taken to suggest or indicate a disease process. At no point does he offer any discussion of, '*syndrome*': it is fait accompli. His classification of MS falls into three main types, which actually would account for the bulk of hospital emergencies: abdominal, haemorrhagic and neurological. This further affirms MS as a medically valid concept. In the case-vignettes, which Asher refers to as '*Illustrative Case Records*' (p339) he describes '*three cases of the abdominal type of Munchausen's syndrome*' with which he demonstrates *typical* features as well as *advanced* and *milder* forms.

Although Asher (1951) recognises that patients may be ill, his emphasis remains on the falsehood accompanying the presentations which for him define the syndrome. This is perhaps understandable. In the literature following Asher's (1951) paper, Clark and Melnick (1958) observed that this type of dissembling behaviour confounds and threatens diagnosis. The emergent emphasis and preoccupation, however, is not sited in the effects of the behaviour on the patient but *on the Doctor.* Asher's focus was to construct bonds between Doctors as victims of patient trickery rather than as professionals with a common problem for diagnosis.

Interestingly, it is evident from Asher's description of the case of patient Thomas Beeches that he refers to being consulted by a Doctor, in another hospital. '*Knowing my interest in Munchausen's Syndrome*' as early as 1949. He had clearly already established a reputation prior to the publication of the 1951 paper.

Asher's (1951) focus on the individual behavioural characteristics of patients, which he invariably describes as exhibiting, *persistence*, *truculence, evasiveness* and *pathological lying* diverts from other possible explanations; even those, which might support a psychological explanation. His use of broad labels such as *hysterics, schizophrenic* and *masochistic* to describe a *group*, which show '*a constant pattern of behaviour* (p339) represents a mixture of psychiatric diagnostic labelling and behavioural description, none of which account for the motivation to present factitiously to Doctors. He recognises 'a *twist of personality'* and, finally, in his summary, *'a psychological kink, which produces the disease'* (p341) but offers no analysis beyond this. Asher (1951) was either unaware or unaffected by historical theories (Menninger 1934, Freud 1890 onwards) or the perspectives of those contemporary to him. The emphasis of Asher's paper nudges out analytical thinking: a criticism which can be extended to describe the medical correspondence, which ensued both in Britain and America and which was to be later replicated in the establishment of Msbp. This is reviewed below.

A later paper by Clyne (1955) stands out fairly uniquely in its criticism of Asher's (1951) paper on Munchausen Syndrome and is one of the first to raise questions in respect of its validity as an illness construct. Clyne (1955) raises the issue of misdiagnosis and the culpability of Doctors, who organise useless investigations and treatments (recently available in the then new N.H.S.) only to come to the inevitable conclusion that the correct diagnosis is a *psychiatric* one. In Clyne's view, it does not therefore become the fault of the patient that '*his medical advisors got a hold of the stick by the wrong end'* (p1207). Clyne (1955) saw no need for any *condition* labelled Munchausen Syndrome.

In Asher's description of the cases of Thomas Beeches, Margaret Coke and Elsie de Coverley, apart from the fanciful and falsified histories, which they provided, each showed evidence, on examination, of previous operations and each had been subjected to extreme medical checking and procedures such as laparoscopy and

gastroscopy. All had tendencies to discharge themselves against advice and to fail to cooperate with attempts to help them. Essentially, however, their elaborate stories and case-histories, truculent uncooperative behaviour and itinerant nature caused Asher to construct them as being a particular discreet group of patients constituting Munchausen Syndrome.

It is clear, however, from a reading of the albeit brief case-histories that other interpretations may be possible and while it is possible to speculate on the psychological motivation of the patients, which may have given rise to their behaviour, and provided a motivation for them to falsify their histories, each had very apparent genuine medical and likely painful complaints. Thomas Beeches *did* present with a discharging wound, which may or may not have resulted from a war injury, as he claimed. Likewise, Margaret Coke's documented urinary and abdominal complaints may have come about from her life as a prostitute in London's Piccadilly. It is possible also that both were drug addicts, pain being either the result of or the cause of their addiction since both discharged themselves – against advice – after being prescribed morphine. Irrespective of their falsified presentations, they clearly generated medical concern while in hospital and when they discharged themselves from hospital. That Margaret Coke was found collapsed in the street by Police having discharged herself from a hospital the previous day after being admitted for '*suspected acute intestinal obstruction*' might conceivably support this re-interpretation of the available information. (Allison and Roberts 1998).

In the case of the second female patient, Elsie de Coverley, Asher again describes the characteristic multiple admissions to hospitals and the challenging behaviour, which often characteristically culminated in patients discharging themselves from hospital against advice as did Elsie de Coverley. However the most telling comment is the patients own, recorded by Asher, himself, that '*no-one really thought she was in pain*'. It is not beyond the bounds of possibility that Elsie de Coverley went from

hospital to hospital in the search for a cure or even that her behaviour was better accounted for by hypochondrias, although like Thomas Beeches and Margaret Cole she *did* have a pre-existing condition. On examination, Elsie de Coverley had a mitral pre-systolic murmur, although this might not have accounted for her presentation with pain.

Asher (1951) does not consider as Clyne (1955) subsequently did that misdiagnosis or missed-diagnosis might account for the presentations he described and which he was asked to consult on as a Psychiatrist. Rather, the evidence of frequent presentations to hospitals with elaborated case histories is used against the patients as evidence of duplicity against the medical profession. (Allison and Roberts 1998) At no point does Asher consider the effects on the patient. He writes essentially from the standpoint of medical centricity. Nor does he recognise what would now be referred to as wider psycho-social risk factors such as pre-welfare-state poverty, a lack of, or poor family or community supports, the after effects of warfare on servicemen or, broadly put, psychological distress and disturbance, which it is fair to have expected Asher, as a Psychiatrist to recognise. He patently failed to do so.

Asher's (1951) lack of any clear establishment of *motivation*, a fact that he himself acknowledges: '*supplementing the scanty motives, there probably exists some strange twist of personality*' (p339), provides opportunities for subsequent writers to provide their own particularly in respect of Msbp. (Allison and Roberts 1998) Asher offers a range of possible explanations, from the practical i.e. to obtain lodgings, drugs or escape from the police to deliberate attempts to dupe Doctors. His reference to the '*desire to be the centre of interest and attention*', perhaps paved the way for future interpretations of *motivation* in respect of Msbp.

By the time of Meadow's (1977) conceptualisation of Msbp, Asher's illness metaphor, in combination with the behavioural characteristics of problematic adults is extended to describe the medical abuse of children, the motivation of the adult-

perpetrator being 'to assume the sick-role'. In Meadow's transmutation of MS to Msbp, behaviour *again becomes psychological illness,* thereby providing the central confusion in what is a form of child abuse and more appropriately described as such.

As noted above, Asher's paper is notable as much for what it isn't as for what it is. Even without the benefit of hindsight, his analysis and understanding of the patients, whom he saw as a Psychiatrist, is woefully inadequate. That the paper jumped the hurdle of the editorial board of the Lancet is also remarkable, Asher's combination of anecdote and humour clearly easing its passage: such journalistic devices are widely utilised by later writers in the Munchausen literature. Two of the best examples are provided by Strettan (1951) and Priest (1951) who, writing separately, but within two weeks of Asher, both parodied a music-hall song 'I wonder who's kissing her now' in reference to their own individual case notifications (Allison and Roberts 1998). In a journalistic atmosphere, in which one colleague acknowledged the humour of another in effectively decrying patients, it was clearly open-season.

The literature to be discussed below provides examples of what in modern euphemistic terms would be called unprofessional practice. Nowadays, most of it would never be printed. However, by way of an aside, the writer has read the term 'pathological liar' in a G.P.s case-notes, in reference to a woman suspected of falsifying her child's illness. Doctors clearly do not expect these to be read!

The Post Asher Phase

That there is a willingness to unquestioningly accept Asher's description of the behavioural characteristics of patients as constituting Munchausen Syndrome, while suspending critical faculties, is demonstrated by a paper, which came hard on the heels of Asher's (1951). Williams (1951) describes the presentation of a sailor in the Hammersmith Hospital, London, who claimed to have received wounds at the battle

of Zeebrugge. This may or may not have been evidenced by abdominal scarring found on examination. William's describes him as departing '*after much disturbance*' – presumably to re-enact the scenario elsewhere having achieved success in the Hammersmith Hospital by obtaining morphine. Apart from the specifics of the sailor's presentation, this scenario i.e. the demand for drugs, is likely to be a familiar one recognised by most Doctors across the country. That this behaviour was construed by Williams (1951) as a diagnosable disorder rather than a likely means and ruse to obtain drugs, is somewhat remarkable. That it was accepted and published in The Lancet, even more so.

Initial responses to Asher's (1951) paper were enthusiastic about picking up his theme of surveillance and identification as well as focussing on the pathological aspects of patients. Strettan (1951), writing to the Lancet in the week following Asher's (1951) paper congratulated him and suggested a central register be kept in the London Hospitals. He described the case of a man who presented at St Giles and Dulwich Hospitals on the same day with abdominal pain. He rigidly applied Asher's diagnostic criteria to the extent that he saw the patient discharging himself and having visited two hospitals on the same day as confirmatory of what he '*surely*' saw as '*a disease*'.

In the same February 1951 edition of The Lancet, Priest offered an example of the syndrome by providing not only a trawl of his memory but, presumably, his case notes. He anecdotally described the case history of a patient he recalled from 20 years previously, who in the early 1930s '*haunted London Hospitals*". This patient, admitted with suspected amoebic hepatitis was troublesome and difficult to examine and, therefore, discharged from two hospitals on the same day. He was to be described *20 years later* by Priest (1951) as '*a good example of this Syndrome*'.

In the next Lancet edition Todd (1951), attacked '*Munchausen Sufferers*' as '*inadequate psychopaths*' albeit he recognised the motivation of some may have been to obtain morphine.

The Munchausen literature is remarkable in generally providing highly questionable case descriptions of patients with scant evidence of analysis as to *why* the patients behaved as they did. The delinquency aspect of troublesome '*Munchausen patients*' preoccupied Doctors to the extent that some considered dispensing with confidentiality altogether.

As noted earlier, it is not the purpose here to dispute the existence of patients who falsify medical histories either for themselves of for others and the problems these present to Doctors and those responsible for resource management. However such cases surely constitute '*problems for diagnosis*', as was argued by a contemporary writer Clyne (1955) rather than requiring of surveillance and monitoring. After all, presumably a patient - even one recorded with a history of presenting with falsified illness – if this were ever to be possible – would require examination and assessment on each occasion s/he presented to a Doctor, as being ill.

There is something of a hint in a paper by Clark and Melnick (1958) as to why Asher's description of the *typical* Munchausen presentation, might have rung true with his contemporise. Clark and Melnick (1958) suggest that the newly established state system of medicine i.e. N.H.S. actively engendered Munchausen Syndrome. That this phenomenon has been also highlighted in a more contemporary paper, in respect of Msbp presentations in countries developing western approaches to medicine, in terms of service delivery and diagnostic services (Feldman and Brown 2002) is surely significant.

Inevitably, any state service, free at the point of delivery, is subject to an unquantifiable amount of abuse and likely over-use. Doctors working in 1950s

Britain were perhaps unprepared for the increase in patients crossing their doors post 1948 after the implementation of the N.H.S. Act (1946). A flavour of this might be reflected in their post 1951 case notifications of patients, in whom they saw parallels with Asher's (1951) group of nuisance time-wasters. Bearing in mind that the majority of Doctors opposed the setting up of the N.H.S. and orchestrated opposition to the 1943 white paper, through the B.M.A: it is perhaps to be anticipated that Asher's paper provoked responses from Doctors, more willing to engage with the behavioural characteristics of patients, whom they *recognised* as nuisances and as posing threats to their medical acumen rather than with wider issues in respect of diagnosis and syndrome validity. Highlighting a group of patients might also have a compounding effect suggesting that there were actually more of such presentations than there really were.

The medical literature, thereafter, affirmed Asher's (1951) conceptualisation of Munchausen Syndrome. Problematic *duplicitous* behaviour among delinquent patients, in conjunction with evidence of pre-existing medical interventions and/or illness established the defining pattern later adopted in definitions of Munchausen Syndrome by Proxy (Rosenberg 1987, Meadow 1995, 2002).

The next phase in the establishment of the Munchausen history emerged several years later. That Doctors continue to be thwarted and annoyed by specific patients is evidenced by an irate Dr Short, who, writing to the British Medical Journal suggested 'a *rogues gallery'* to protect Hospitals, at least in the London area. However, several writers famously stand out from the rest in their clear contempt for the type of patient described by Asher (1951).

Clark and Melnick (1958) running with the theme of nuisance patients exploiting and wasting resources, described '*The Munchausen Syndrome or the problem of Hospital Hoboes'*. Their paper somewhat typically alludes clearly and deferentially to Asher's 1951 paper as much of the literature continues to do. There are, in

reality, few published examples of criticism of Asher. The recursive nature of case notifications is significant in establishing the validity and uniformity of Munchausen Syndrome and later Munchausen Syndrome by Proxy (Allison and Roberts 1998, Mart 2002, Eminson and Postlethwaite 2000).

Clark and Melnick (1958) added three cases to the Munchausen literature, which was amassed over the years, subsequent to Asher's paper. The most noteworthy case is that of a female railway worker cited as a 'typical' example of Munchausen Syndrome, who presented over years to various hospitals with a range of gastro-intestinal and gynaecological problems. These admissions resulted in six laparoscopies, an appendectomy and a hysterectomy. She also had psychiatric admissions, during which E.C.T. was administered. Her background in crime (and her families) as well as her time as a prostitute are used in evidence against her, by Clark and Melnick, as representing a continuum of problematic behaviours, which further confirmed her as a 'Munchausen' patient.

What Clark and Melnick's (1958) paper represents is an interpretation of a patient's medical needs, determined primarily by behavioural characteristics. That the railway worker is detained at various times in her life as a result of this behaviour and unwillingly in psychiatric hospitals, only succeeds in confirming the interpretation of her as *mentally* unstable.

To the modern reader, irrespective of the motivation of the railway worker, she was in effect extensively and serially abused by the profession, from whom she sought help. The medical procedures aside, she was subjected to aggressive psychiatric procedures such as electro-convulsive treatment. Psychometrics likewise *confirmed* her as being narcissistic, ego-centric and emotionally immature, which affirmed her further as inadequate. Irrespective of this and mindful of the epitaph of a well-known self-confessed hypochondriac and comedian *'I told you I was ill'* it might have been the case that the railway worker *was ill.* Vague pain, of either gastro-

intestinal or gynaecological (or both concurrently) origin, will be recognised by most women and equally Doctors, as a difficult diagnostic puzzle. In their drive to establish duplicity as '*another evil of a state system of medicine*' as well as highlighting a real threat to their capacity to diagnose genuine illness, Clark and Melnick fail to recognise the flaws in their own thinking.

As a general observation, the post-Asher (1951) era is characterised by a consistent failure in the literature to engage with the possibility that some of the case notifications might be examples of misdiagnosis. So reassured were the Doctors, who responded to Asher's (1951) call for responses, that the behavioural presentations and affect of patients matched Asher's description of Munchausen Syndrome that there appeared to be little need to offer different explanations or to interpret patients needs more humanely, within for example the context of socio-economic or psychological stressors, in post-war Britain.

That the railway worker's psychiatric condition i.e. depression might result from her medical difficulties, which at one point resulted in a complete hysterectomy, is minimised by Clark and Melnick (1958). All information conspires to construct and confirm the railway worker as a source of nuisance to the medical profession, which emerges as morally superior and put upon. (Allison and Roberts 1998). Issues of poor or misdiagnosis resulting in what is evidently extensive medical and psychological abuse, are never recognised or considered by Clark and Melnick (1958). In the absence of patient cooperation, it is clearly a short road from medical problem to nuisance patient, with consequences of detention in psychiatric hospitals and barbaric aggressive regimes.

Finally, one of the most challenging papers to the modern reader but the more interesting as a result is that produced by Chapman (1957). Cited as providing some of the worst examples of antagonistic and punitive acts against a problem patient (Szasz 1974) in three letters to the Journal of the American Medical Association

(1955, 1957) Chapman described the case of Leo Lamphere merchant seaman and professional wrestler, who was also know, according to Chapman, as *The Indiana Cyclone.* Lamphere wondered from hospital to hospital, in the East coast of America, over a period of 16 years starting in Iowa and re-surfacing in the Bellevue Iowa Hospital in New York, where he was recognised as the *'famous case of Munchausen's Syndrome'* by Cramer et al in 1971. He was also the subject of an article by Time Magazine. This case provides the root example of Munchausen Syndrome in America and established the syndrome there (Allison and Roberts 1998).

Deference and acknowledgement of Asher's (1951) contribution is writ large in Chapman's papers about Lamphere in that the medicalisation of the patient, emerges from Chapman's observation of behavioural characteristics first defined by Asher: Lamphere's truculence and lack of compliance, in combination with his itinerant habits effectively confirmed the Munchausen Syndrome diagnosis for Chapman. The emphasis also - away from the Doctor to the patient-renders the patient wholly responsible. (Allison and Roberts 1998). The later literature in respect of Msbp, while recognising the role of Doctors, will offer wider explanations for their role in maintaining Msbp child abuse (Eminson and Postlethwaite 2000) and will tackle this issue more honestly.

It is clear that Chapman (1957) disliked Leo Lamphere and was obsessed with his case to the extent that he corresponded with many hospitals and Doctors about him in the years following his own clinical contact. (Allison and Roberts 1998). He offers no socio-economic or medical psychological perspective on a man, who may have become a demerol addict as a result of severe leg pain, associated with thrombophlebitis, and varicose veins, for which he received surgery. Some of this, at least, may conceivably have been work-related.

When he is admitted to the Bellevue Hospital (N.Y) 16 years later, it is again for abscessing and ulcers on his legs, for which he is prescribed Demerol. The psychosis noted by Cramer et al (1971), at this point, may, in fact, have come about through Lamphere's drug-addiction, associated with years of pain, as indeed might some of his later physical complaints. By this stage in Lamphere's history, Cramer et al (1971) note that he hated Doctors and Hospitals, perhaps with cause. This might conceivably explain his expeditious departures from hospital, described by Chapman (1951) and on one particular occasion, from the operating-table, tubes etc 'in situ'.

Chapman (1955, 1957) offers little interpretation of Lamphere's behaviour beyond how it impacts on him. His detailing of Lamphere is remarkable for the level of annoyance shown by Chapman as is his construction of him as an impostor. The fact that it was always clear that Lamphere was probably a drug-addict does not divert Chapman to consider this a factor in his behaviour. His analysis of motivation does not extend beyond recognising that the need for drugs might motivate some patients as might '*a grudge*' against Doctors, the need for board and lodgings or a pathological pleasure from being a patient. Like Asher (1951) before him, Chapman's parroting of what is in effect, a very inclusive and comprehensive list of motivations, actually provides little that is insightful or new. Characteristically, in the post Asher literature, all patients fitting the prescribed profile of behavioural characteristics are reduced to imposturing and are constructed as threats (*rather than challenges*) to the business of accurate diagnosis.

As noted above, there is little criticism of this interpretation during the critical few weeks post Asher's 1951 paper when MS is established. It is not until Clyne (1955) that there is any recorded objection, which as will be remembered, contributed the possibility of misdiagnosis, which could not be blamed on the patients.

As a general comment, Doctors have not readily been able to see themselves as playing a major contributing role in the maintenance – if not engendering of factitious presentations. Later writers address this (Eminson and Postlethwaite 2000) although the first writers to 'pick up' such cases devolved responsibility away from themselves to their patients and were, as a result, self-exculpated. (Allison and Roberts 1998).

By the time of Lamphere's reincarnation in the Bellevue Hospital, NY, 16 years later, his case is given a more sympathetic and less judgemental handling by Cramer and his team (1971). Described with two other cases, their psychodynamic interpretation of the Doctor-patient relationship and power dynamic echoed that of Freud and Menninger (1934). However, even during this era, systemic or environmental issues, which might have offered different perspectives or which might have scaffolded the behaviour of their patients are not explored.

The significance of this paper (1971) lies in the shift it provides in conceptualising Munchausen Syndrome within psychodynamic theory thereby paving the way for Meadows (1977) paper on Msbp and later, the notion of unconscious motivation i.e. *to assume the sick role*. Cramer et al (1971), in suggesting that patients presenting with Munchausen Syndrome were often both physically and psychologically ill – as clearly might be the case – provided for intra-psychic explanations for factitious disorders (Allison and Roberts 1998) and established *Munchausen behavi*our as lying in the *unconscious*. It is worth noting at this stage in the review that earlier writers such as Brodie and Charot, as described above would have recognised much of this debate. The central issue relates to *conscious awareness* and, therefore, *volition*. This has later implications for interpreting acts of child abuse, which are therefore better understood in terms of harm to the child irregardless of the motivation of the perpetrator. As noted from the start, understanding motivation is useful at different stages in the conduct of a case: for example, in managing parental behaviour and in family rehabilitation should this ever be possible. A parent's

psychological condition should never define the abuse of a child. This is recognised in recent guidance (Royal College of Paediatrics and Child Health 2002).

Interestingly, some of the content of Lamphere's developmental history, reported in the 1971 paper, presumably arising from therapy, reveals a very troubled childhood spent in care homes and is characterised by abuse and neglect. His adult life was not much happier. It was during this phase that Lamphere suggested that Dr Chapman's earlier antagonisms towards him had arisen subsequent to Lamphere rejecting his homosexual advances. It is clearly unwise to draw any conclusions from this revelation beyond offering the (hazardous) opinion that such revelations might more typically emerge from psychotherapeutic contexts, such as that provided by psychoanalysis, than perhaps from other approaches to therapy.

Much of this particular literature is clearly vindictive and written specifically to highlight the troublesome and problematic nature of factitious presentations sic *Munchausen Syndrome.* The psychoanalytical slant, which broadly characterised psychology and psychiatry in the 1960s and 1970s provided opportunities to explore the psycho-dynamic orientation of the Doctor-patient relationship. This has already been referred to above in relation to Freudian concepts of *transference*, which both reflects and coincides with societally determined and ascribed gender roles. (Motz 2001). This latter component provided the focus for contemporary feminist literature. These emphases were notably reflected in the work of Herbert Schreier and Judith Libow, respectively, as co-authors of '*Hurting For Love: Munchausen by Proxy Syndrome*' (1993), described below. Allison and Roberts (1998) in their appraisal of the influence of '*Hurting For Love*' suggest that it remains the most influential text in the Mbp literature and the one most referred to in legal contexts.

Above all, however, and this provokes criticism from Allison and Roberts (1998), with the publication of 'Hurting For Love' Msbp became a diagnosable psychiatric condition, thereby completing a process, which began with Asher's (1951)

speculation about Munchausen Syndrome as perhaps resulting from a psychological 'kink' ending in Meadow's (1977) attempt to make an intellectual link to Munchausen Syndrome and the provision in the 1977 paper of Meadow's own speculation above the motivation of women to abuse their own children, derived from behavioural observations in hospitals.

Background Considerations To 'The Hinterland of Child Abuse' Meadow (1977)

In keeping with the process of case notification subsequent to Asher's (1951) paper, as charted above, the ensuing literature, post Meadow (1977) engaged with issues of motivation, which evolved to become diagnostic criteria (Rosenberg 1987, Meadow 1995, 2002). This will be reviewed below when issues in respect of *motivation* are addressed.

It is useful to set this and specifically Meadows (1977) paper against the backdrop of wider developments in the recognition and understanding of child abuse. Although Meadow's (1977) paper engaged primarily with the child abuse literature relating specifically to non-accidental poisoning and fabrication of illness, the now added element of parental *motivation* to abuse through illness falsification or fabrication as explored in the 1977 paper, effectively differentiated Msbp from other forms of child abuse, then and now. As argued throughout this has provided the central element of confusion as to what and to whom Msbp refers.

The dynamics of Msbp abuse, which rely primarily on the unconscious complicity of members of a very powerful professional group, accustomed to constructing troublesome or unacceptable behaviour within medical models of disease, is likely to provide some explanation of this. Although themselves victimised in the abuse triangulation of Mother – Child – Doctor, they also get to define it!

Paediatricians, by the very nature of their contact with children, have long been exposed to cruelty against them. The association of fractures and subdural haematoma with wilful violence (Wilson BMJ 2001) has been known about since the post-war years but addressed in the landmark paper 'The battered Child Syndrome' (Kempe et al 1962). This, in turn, stimulated Department of Health Guidelines (1970), which attempted to provide a standardised approach to paediatric practice in this area.

The earliest reported cases of paediatric factitious presentations are therefore to be found associated in the medical literature with non-accidental poisoning. Paediatricians were clearly making the intellectual link with the language of research associated with the physical abuse of children. (Eminson and Postlethwaite 2000). Pickering (1964) notified three cases of salycilate poisoning, which he later came to describe as '*a manifestation of the battered child syndrome*'. Some years later, Rogers et al (1976) produced a review of six cases of non-accidental poisoning referred to as '*an extended syndrome of child abuse*'. Dine (1976) produced a single case report entitled '*Tranquillizer poisoning: an example of child abuse*'.

One element of significance of Meadow's 1977 paper lies in the connection it provides between the child protection literature on non-accidental poisoning (and injury) and the psychiatric component of abnormal illness behaviour in adults either for themselves or their children (Eminson and Postlethwaite 2000). The linking factors being deception and misrepresentation of health status and the need for treatment.

Before examining Meadow's 1977 paper in detail, a paper written by Burman and Stevens (1977) merits discussion. Published within weeks of Meadow's own, they describe the case of two children presented respectively with diabetes and '*bizarre neurological symptoms*', which was later found to be due to promethazine poisoning. Both children became well after separation from their mother.

The fact that mothers in both Meadow's (1977) and, later, Burman and Steven's (1977) notifications exhibited signs of abnormal illness behaviour in themselves, strengthened further the link, in the minds of Paediatricians between Munchausen Syndrome and child abuse. That this became Munchausen Syndrome by Proxy is as much due to linguistic artefact (Meadow 1995) than research-based evidence. This then becomes literally the defining moment when a form of child abuse becomes cloaked in medical and pseudo-medical terminology rather than integrated into social science/child protection models (Eminson and Postlethwaite 2000, Eminson and Jureidini 2003). Although understanding of this form of child abuse continues to evolve, the fundamental *core* aspects, as laid down by Rosenberg (1987) and later Meadow (1995, 2000, 2002), have changed little. The bulk of the professional literature, subsequently, has concerned itself with operationalising the definition and generally refining understanding.

Munchausen Syndrome by Proxy: The Hinterland of Child Abuse (1977)

Although there are earlier reported cases of illness falsification in children (Sneed and Bell 1976, Money and Werlas 1976) this is considered the central paper describing the deliberate harm of children, by a parent, stemming from illness falsification. Meadow is accredited with the description of the first two cases of *Munchausen Syndrome by Proxy.* His theorising about a form of child abuse, which he differentiates from cases of non-accidental poisoning, which were being amassed in the child protection literature (Rogers et al 1976), draws much of its substance from Asher's (1951) description of adult abnormal illness behaviour and somatising disorders (Munchausen Syndrome). Making intellectual links with the characteristics of MS as observed by Asher (1951), provides subsequently the predominant framework for describing a manifestation of child abuse, embedded in theories of adult psychopathology. Evidence of abnormal illness behaviour in at least one of the mothers in Meadow's sample, in concert with case-reporting by

other Paediatricians (Burman and Stevens 1977) strengthened the link between MS and Msbp. However, questions about the conceptual validity of both pivot on issues of definition and most significantly *motivation,* which is not addressed clearly by Meadow in the 1977 paper and remains a conspicuous problem (Eminson and Postlethwaite 2000).

By way of an omission, it is never clear from Meadow's 1977 summary whether Msbp is used by him in reference to maternal behaviour, to the process of falsification per se or to the child as victim. Problems in definition will be described below but suffice to say at this stage that they have provided problems for decades (Baldwin 1996 Meadow 1995, 2000) and continue to do so, particularly among non-clinicians and the media, which shares some responsibility for perpetuating public misunderstanding of Msbp and what it is.

This point is made by Baldwin (1996). With specific reference to the Allitt Inquiry (Clothier Report 1994): he states

"*... in May 1993, the case of Beverley Allitt hit the headlines and Msbp came in the popular mind, at least, to be associated with serial murder. The fact that the Clothier Report concluded that the term Msbp was unhelpful in this context was not widely reported, and did nothing to dissociate the syndrome from serial murder. This is unfortunate, as any debate surrounding the concept is now clouded by that particular popular misconception (lines 3-12).*

Although a great deal of specific clinical detail is provided by Meadow about the abuse of the two index children – Kay and Charles – the main emphasis of the paper remains on (1) perverse duplicitious maternal behaviour as a key profile marker characterised by (2) the provision of false medical histories in respect of a child, resulting in (3) child abuse. While recognising the experience of both children as having been abusive – '*none can doubt that these two children were abused*' – no analysis is available from Meadow, in his 1977 paper, of how the context, in which the abuse took place, might be implicated or how Doctors might have operationalised the abuse of Kay, in particular, who was subjected to years of

unnecessary medical treatment and intervention. Although Meadow (2002) does come to acknowledge this in a later paper, in the 1977 paper there is only speculation about how the modern trend towards open access to paediatric wards may have facilitated the abuse of Kay, by allowing her mother access to medical samples, which she could contaminate.

As far as Meadow is concerned, the false histories, provided by both mothers, (and actions, presumably) equate with deliberate deceit and trickery, confounding diagnosis and treatment rather than challenges for assessment. This is evident, in what can best be described as a bizarre tribute to his colleagues, whom he vindicates. In an exculpatory final paragraph, referring to the deceitful nature of both mothers, he states, with an element of contradiction it should be said:

"This paper is dedicated to the many caring and conscientious Doctors, who tried to help these families and who, although deceived, will rightly continue to believe what most parents say about their children, most of the time".

Eminson and Postlethwaite (2000) will later describe this *as a breach in the bargain,* by which children are brought by a parent, seeking health care, which is delivered in good faith based on the history provided by that parent. They recognise the iatrogenic nature of Msbp abuse and how medical practice is implicated; in particular, often through a lack of adequate medical history.

In a comparatively recent paper (2002) re-visiting definitions of Msbp abuse, Meadow states:

*The contribution of Doctors and other health professionals to the abuse has long been recognised, and the pressures from both professional pride and litigation have, at times, been a forceful barrier to the identification of abuse and the safeguarding of children in the family. It is less easy for Doctors to identify abuse when they recognise that they, themselves, are implicated actively or passively in that abuse (*lines 24-29*).*

Based on Meadow's (1977) account of both cases, but Kay's in particular, following a forensic investigation which proved sample contamination, there was adequate

evidence to support charges of child abuse against her mother, who fabricated urinary tract infections in her daughter over a period of six years. At post-mortem, physical signs of chemical ingestion were compatible with Charles' history of hypernatraemia between the ages of 6 weeks to his death at 18 months. His age and the time span making it highly improbable that he caused this harm accidentally, to himself. Where the paper wanders is in the links made to adult factitious disorders sic *Munchausen Syndrome*, as a mechanism for accounting for the mothers' actions, which Meadow referred to as ' *a sort of Munchausen Syndrome by Proxy* (1977 line 6).

This immediately has the effect of *pathologising* maternal behaviour, and provides for the definition of acts of child abuse within disease models (Parton 1985). Apart from stressing the abnormal illness behaviour of both mothers for themselves, no other explanation for maternal behaviour are considered in Meadow's paper. Meadow's (1977) interest in wider aspects of their functioning, which might provide wider explanations for their behaviour is not there.

Evidence that Kay's mother fabricated urinary tract infections in herself is taken only as corroborative of her abuse of Kay rather than indicating a potential *absence* of clinical enquiry into her own psychological functioning. More particularly, that the mother of Charles tried to commit suicide after her child's death is dealt with incidentally. Post natal depression resulting in fatal child abuse(Reder and Duncan 1999) might have offered an alternative explanation to Msbp as might faults in mother-child attachment (Jones et al 2000).

Clearly, there is an element of speculation here, in the absence of a whole case background. The point is nonetheless made that Meadow's absorption of Asher's (1951) model in effect, even unintentionally, precluded other possibilities for accounting for maternal behaviour and consequent child abuse. Instead, key

behavioural elements providing 'an alert' are used to differentiate out *Munchausen Mothers* which clearly relate to features akin to Asher's description of MS so that consequentially, *'dramatic and untruthful stories'*, *'the tendency to discharge themselves when the game is up'*, *and 'travelling widely for treatment'*, will later heavily influence 'profile markers' in hospital settings. Meadow's description of them as *'caring and loving'*, *'pleasant people to deal with'* and *'cooperative and appreciative .... which encouraged us to try all the harder'* provides the component of duplicity, which later becomes a profile cornerstone.

What might be described as paradoxical parenting provides the greatest challenges to Doctors, not only clinically, in being sent off often on wild goose chases, but emotionally, in the recognition of being deliberately mislead. Much of the anger, which characterised the early case-reporting of Munchausen Syndrome reflected this. The Msbp literature is more restrained in describing often gross acts of child abuse and behaviour.

However, by way of a chilling observation, it is worth noting the consequences for Kay: *'to try all the harder'* amounted to a catalogue of 12 hospital admissions, 7 major x-ray procedures, 6 examinations under anaesthetic (urological and gynaecological) 5 cystoscopies, toxic drug regimes and a range of creams, medication and pessaries. One hundred and fifty cultures of her urine were made. Overall, sixteen consultants were involved at some stage in her assessment and care. (Allison and Roberts 1998).

Although Meadow (1995) later acknowledges using Munchausen Syndrome as a journalistic device only, the effect of the paper is in constructing a syndrome variant without any apparent clinical reservations about Asher's original paper, particularly in respect of the use of 'syndrome'. In the absence of any critical thinking about Asher's (1951) paper and available research, this position was perhaps tenable then.

However, over 30 years on, the same questions about formulation generally persist. In this medical transmutation, *patient* (MS) easily becomes *mother* (Msbp). Alison and Roberts (1998) have argued that by drawing on behavioural profiles in the historical sources, Meadow's (1977) paper validated Munchausen Syndrome. By a process of reification: *'Here is described a syndrome, which most Doctors have seen'* (Asher 1951, Meadow 1977) both emerge fully fledged and irrevocably interwoven. Mart (2002) sums up the inherent dangers of case reification: *'... there is a natural tendency to treat abstract or theoretical constructs as though they were concrete events or physical entities. The simple act of having a theoretical construct tends to lead people to believe that it exists, particularly as the term becomes generally familiar (p17-18).*

In summing up Meadow's paper, it is argued that his uncritical adoption of Asher's 1951 description of Munchausen Syndrome, in adults, to describe a manifestation of child abuse, precluded any real analysis of these acts of abuse and what gave rise to them in the first place. Meadow's intention to differentiate Msbp from non-accidental injury based on the specifics of maternal behaviour has the effect of situating a form of child abuse within a medical 'disease model' through the failure to consider a broader more systemic perspective. In the hypothetical absence of Asher's paper, how might Meadow have described Msbp?

By 1977, behavioural characteristics *'reminiscent of Munchausen Syndrome'* come to be used both *descriptively* of duplicitous behaviour in mothers and *diagnostically* of a form of child abuse in medical settings. This was compounded by the misleading use of the medical label *syndrome,* as described above. The linking factor was individual psychopathology. Confusion as to their inter-relatedness springs from the juxtra-positioning of both of these elements, without any clear route of causality that might explain unnecessary presentations to the medical establishment either for self or a dependent child. Citing individual

psychopathology as evidenced by *motivation* as cornerstones of Msbp provides its most conspicuous problem, which is only superficially explored by Meadow (1977).

He offers very little in the way of discussion of *motivation* beyond raising possibilities, which nonetheless crucially embed motivation within the realms of psychodynamic theory, which will later evolve to provide the criterion of '*to assume the sick role' (DSM IV T-R 2000)*, which remains fairly central to definitions of Msbp although other forms of attention-seeking behaviour have now been advanced (Kelly and Loader 1997). His ponderings on whether *'both mothers were using the children to get themselves into a sheltered environment of a children's ward surrounded by friendly staff'* and *'The mother of child I (Kay) may have been projecting her worries about her own urinary tract infections to the child in order to escape worries about herself'* reflect mechanisms of transference, as described above.

Meadow's incidental handling of wider contextual factors, which might be implicated in the abuse, such as social and family functioning renders them subordinate to the medico-psychiatric determination of the disorder. Subsequent disciplines will effectively have to begin with this as a starting-point, since the existence and aetiology of the disorder is explained by a patient's need to get the attention of Doctors or to get into a supportive medical environment (Allison and Roberts 1998). This strengthens the medical model further and makes challenges from other disciplines, particularly in matters of clinical validity, heretical.

This construction of Msbp is not incongruent with the history described already here, of providing definitional explanations of behaviour through models of mental *illness* sic individual psychopathology and consolidating this through the employment of *illness metaphors*.

Nearly twenty years after Meadow's paper, Baldwin (1996) comments on this from the standpoint of a more contemporary perspective. Highlighting the problems inherent in what he sees as '*a medicalised and hypochondriacal culture for which the medical establishment is primarily responsible*' he states:

'By looking at the medicalisation of childhood, clinical and social iatrogenesis and the creation of a society obsessed with 'health' and its concomitant illness, it is possible to identify factors other than individual psychopathology, which might explain unnecessary presentations to the medical establishment'.

There are fundamental problems in the core components of Msbp which are unlikely to stand up to objective testing. The bulk of the literature has tended to be descriptive or practical, in nature, without any systematic overview of the development of Msbp, as a concept. This has changed little since Baldwin (1996) raised his concern. Similarly, few writers have engaged with concerns about clinical validity beyond objections to the use of 'syndrome' (Mart 2002), in spite of early papers pointing in this direction (Kendall 1989).

While some components of Msbp abuse are unquestionably real and verifiable through, for example, forensic analysis – as in the case of Kay or through the use of covert video surveillance in contemporary cases of suspected induced apnoea in infants (Southall et al 1997) others are not as readily discernible. Mart (2002) makes this point when delineating the distinction between *explanatory* and *diagnostic* syndromes, in relation to ascribed motivation and maternal behavioural indicators in Msbp. Given that his argument is that there are many circumstances, in which a mother may present a child with induced or fabricated illness, he argues that ascertaining the true motive will be difficult and causality even moreso. This view is also advanced by Morley (1995) and Rosenberg (2003). Also, as he correctly observes, parents, anxious about a child, will display a range of behaviours, which while possibly problematic and attention seeking are not probative of child abuse.

Similar important concerns have been raised in respect of the use of behavioural indicators of abuse in children themselves. The importance of Summits (1983) early paper on '*the accommodation syndrome*' cannot be under-estimated. However, what was intended as an explanatory model describing children's paradoxical reluctance to disclose abuse – so *accommodated* were they to being abused – has, in practice become erroneously translated into a diagnostic model by generations of child care professionals. This, irrespective of the fact that Summit later came to emphasise that the behaviours and reactions he described as likely *indicative* of abuse had never been intended to be used as proof.

Comment has been made on Meadow's lack of acknowledgment of the role that Doctors played in the abuse of the children: Kay in particular. The emphasis on duplicity discharges Doctors and provides a diversion in the shape of maternal psychopathology and, therefore, blame. Subsequent writers will address this through the recognition of the relational processes between mothers, who present their children falsely for medical care and the medical system, which engenders and maintains Msbp abuse (Jureidini 1993, Eminson and Postlethwaite 2000). Modern approaches to diagnosis with reduced emphasis on medical history have likewise been implicated (Eminson and Postlethwaite 2000, Feldman and Brown 2002).

The perfect vision of hindsight has to be recognised, particularly in making judgements about cases, in the absence of direct case experience or the professionals involved or access to case-notes. At this time, Doctors were clearly in the process of developing understanding about wider manifestations of child abuse. Kempe et al's (1962) paper on 'The battered child syndrome' alerted Doctors to patterns of specific features in physical child abuse (non-accidental injury), which could be differentiated from accidental injury. During this period, Paediatrician's legal responsibility to report child abuse to social services was not as formalised as now.

Above all, making the psychological adjustment, which can accommodate *maternal* child abuse, requires the breeching of societal taboos about *mothering.* Msbp has been referred to, perhaps aptly, as 'a perversion of mothering' (Schreier and Libow 1993). This continues to pose problems in recognition and identification, since Doctors remain often slow to consider illness falsification as part of their differential diagnosis (Eminson and Postlethwaite 2000).

Although Meadow wondered how unusual, if not rare Msbp abuse is, subsequent writers dealt with this question differently, embedding Msbp within the context of other models of child abuse and parental behaviour. A useful practical example of this has been provided by Eminson and Postlethwaite (2000). They have advanced a model of parental health-seeking and illness behaviour described against levels of agreement (congruity) with Doctors on a child's need for treatment. They describe parental behaviour on a continuum spanning classical neglect (symptoms ignored) through a *normal* range of behaviour, where there is good agreement on the need to treat, to Msbp (symptoms fabricated). Bearing in mind the reservations expressed above about interpreting parental behaviour in stressful contexts, particularly when a child may be injured or ill - what Baldwin (1996) describes as '*the worried well*', – such a relational model provides an element of comparison on points of convergence and divergence with other models and forms of child abuse. It likewise becomes possible to describe the interpersonal aspect of the mother-Doctor dyad through measures of agreement on treatment, as distinct from models of illness and adult psychopathology. This, in turn, is more likely to dove-tail with established professional protocols for the assessment of harm and risk to a child from abuse and likewise with concepts of Significant Harm, as defined in legislation.

Behavioural characteristics 'reminiscent of Munchausen Syndrome' come to be used descriptively of duplicitous maternal behaviour in respect of seeking unnecessary

care for their children, in medical settings and therefore *diagnostically* of a form of abuse. This differentiated Msbp from the physical abuse, which Paediatricians were more familiar with brought about by non-accidental injury. The linking factor was individual psychopathology and abnormal illness behaviour in mothers for themselves and for their children. Confusion as to the inter-relatedness of Munchausen Syndrome and Munchausen Syndrome by Proxy springs from the juxta positioning of both, without any clear route of causality. The questionable use of *syndrome* has compounded misunderstanding further by lending the authenticity of a clinically valid label and one which suggests that a particular configuration of signs or 'symptoms' indicate a medical condition.

Allison and Roberts (1998) argue that if Msbp is advanced as a syndrome variant then this offers validation of Munchausen Syndrome without any critical engagement with the original source as to its clinical validity. They argue that nowhere in the literature has this been established for Factitious Disorders, Munchausen Syndrome. or Munchausen Syndrome by proxy. Instead of a specifiable object field with a literature, at least minimally coherent, there are discursive narratives reflecting contemporary preoccupations and biases. This is at least true of the historical literature as reviewed above. In respect of Munchausen Syndrome by proxy, they suggest that since there is nothing in the original source to substantiate it, there can be no reason to justify a continuity of 'diagnosis' particularly not of a *syndrome.*

By way of a preface to the review of the professional literature, the previous section has placed Munchausen Syndrome and, by extension Munchausen Syndrome by Proxy within the context of historical theorising about models of mental illness accruing to patterns observed in *abnormal behaviour.* What comes to be determined as *psychopathological* is influenced by prevailing cultural conceptions and is, therefore socially constructed. Psychology and psychiatry in particular, whose

emphasis has lain historically in diagnostic descriptive models, are not immune from these processes (Jansz and Van Drunen (EDS) 2004, Joseph 2007).

Maddux et al (2005) have outlined similar concerns about the nature of psychopathology; arguing that it is a social construct and an abstract idea. At a more practical fundamental level, Maddux et al (2004) have also argued that how psychological *illness* and *well-being* are conceived has implications (predictably) for individuals, mental health professions (in terms of their practice) and government and society as a whole, since our conceptions determine the range and type of behaviours, which need to be explained. Further, the role of mental health professionals, on the whole, falls in line with this and is, therefore, politicised. Proctor (2005) has suggested this applies to research.

By now, it will already be apparent that the fundamental assumption here is that medical methods of categorisation are not useful in the definition of child abuse. The confusion, which this has produced in the general understanding of Msbp is well documented (Morley 1995, Fisher and Mitchell 1995, Baldwin 1996). Meadow attempted to address this confusion as *to what* and *to whom* Msbp applied, in later papers (1995, 2000, 2002).

Chapter 2

The Construction of Munchausen Syndrome and Munchausen Syndrome by Proxy

Issues in the Use and Understanding of Terminology

Understanding Msbp terminology is likely only to be marginally less important than understanding the issues in respect of definition and motivation which will follow in the next section. Both are linked to the point of confusion with regard to how Munchausen Syndrome and Munchausen Syndrome by Proxy are linked and *to what to whom* Msbp refers (Morley 1995, Meadow 1995, 2002).

Asher (1951) coined the term Munchausen Syndrome to describe the activities of patients, who presented falsely with exaggerated tales about symptoms and ailments, occasionally co-existing with genuine illness(es). Asher's patients also often confabulated extensively about their lives and exploits. His use of the nomenclature echoed the tales of the literary Baron Von Munchausen.

An interesting paper by Jill Fisher 'Investigating the Barons' (2006) looks at narrative and nomenclature in Munchausen Syndrome and how narratives that are told about and through Munchausen Syndrome create meaning within medicine. She argues that Munchausen Syndrome and, therefore, the patients themselves come to exist through fictionalised narratives told about them (see Asher 1951 and Chapman 1955). Asher's (1951) first behavioural descriptions of Munchausen's Syndrome, which identified the patients and not their illnesses, set up the analogy for others to follow, resulting in the emergence of Munchausen Syndrome as a disease construct, through what Fisher describes as 'multiple authorship'

Embedding her arguments within theoretical perspectives on the role of narrative in medical practice, by which is understood the dynamics and content of the interaction between Doctor and patient (akin to Baldwin 1996) and cultural perceptions of illness, Fisher argues that medical texts invest meaning in names and names create meaning through narrative. Applied to Munchausen Syndrome, its narratives cast medical and patient participants into pre-established patterns, which impose meaning on their individual experiences, as a consequence. Put more simply, medical (Munchausen, in this case) narratives shape Doctor's experiences of their patients rather than their patient's experience of their illness. Patients come to be understood and framed through Munchausen narratives with inference about motivation and duplicitous behaviour. The evidence of the earliest case notifications would endorse this, including Asher's (1951) own. The Munchausen narrative has the effect also of immediately fictionalising the experience of the patient and emphasises antagonism towards Doctors.

The name Munchausen, when used, creates meaning when applied to patient behaviour and signals something amiss when conjured. The trickster role is emphasised hence the jocular unscientific content of some of the early case-notifications and correspondence from Doctors. This predicates the Doctor-Patient relationship and establishes suppositions about the patient and their illness.

Fisher's (2006) thesis echoes that of Allison and Roberts (1998), who likewise have argued that patients (as in the early MS notifications) come to be known only through the narratives and stories provided by Doctors, as described above. Chapman's (1957) account of the case of Leo Lamphere contrasted with Cramer et al's (1971) later case-reporting of the same case bears witness to this effect.

The same analysis can equally well be applied to Munchausen Syndrome by Proxy. Eminson and Postlethwaite (2000) describe a breach in '*the bargain*' between Doctor and mother, by which a child is presented falsely as requiring of health care,

which is often then delivered in good faith based on maternal reporting of the child's history. Applying Fisher's analysis, this might also then be described as the participants (Doctor and Mother) operating at different narrative levels.

A Tale of Two Barons

The Content of Munchausen Stories

'Central to all of the Munchausen stories is the superhuman Baron who either moves from predicament to predicament or from frolic to frolic. The absurdity of his problems is noticed only by the absurdity of their solutions and the resolution of the stories. Yet beneath the exaggeration and the impossibility of the stories lies, in many cases, a subtle yet keen critique of society. An example of this style of tall tale is relevant to medicine:

I [Baron Munchausen] filled my balloon, brought it over the dome of [the College of Physicians'] building ... and immediately ascended with the whole college to an immense height, where I kept them upwards of three months. You will naturally inquire what they did for food such a length of time? To this I answer, had I kept them suspended twice the time, they would have experienced no inconvenience on that account, so amply, or rather extravagantly, had they spread their table for that day's feasting. Though this was meant as an innocent frolic, it was productive of much mischief to several respectable characters amongst the clergy, undertakers, sextons, and grave-diggers: they were, it must be acknowledged, sufferers; for it is a well-known fact, that during the three months the college was suspended in the air, and therefore incapable of attending their patients, no deaths happened, except a few who fell before the scythe of Father Time ....

If the apothecaries had not been very active during the above time, half the undertakers in all probability would have been bankrupts'.
(Surprising Adventures of Baron Munchausen, pp. 82-83).

Jill Fisher: 'Investigating the Barons' Perspectives in Biology and Medicine (2006).

Baron Hieronymous Carl Friedrich Munchausen was born near Hanover, Germany, in 1720. He became a famous raconteur, much celebrated in society and in demand for his tales of his military campaigns in Russia. To the Baron's annoyance his tales were plagiarised and published by a scientist called Raspe, whose identity was revealed only in 1794, by which time other authors had added their own tales, which were somewhat *fantastical* and not attributable to the original Baron Von Munchausen, who withdrew from celebrity life. The metaphor is ripe with possibilities! The Munchausen name, therefore, emerges from both the historical and literary Baron.

Asher's use of 'Munchausen' spawned 50 years of debate as to its appropriateness. Doctors wrote immediately on the publication of Asher's 1951 paper to *The Lancet*, in defence of the Baron's reputation. Some of the content of the correspondence is noted here to mark the point made above that the majority of Doctors were preoccupied with matters other than medical ones in respect of their patients. As Fisher (2006) observes, the medical correspondence served as both literary and historical guides to the Baron and Munchausen Syndrome and is noted here as quite remarkable in its content as is the whole Munchausen history, reviewed above.

Wingate (1951) began a correspondence about the appropriateness of the name, which continues. Taylor (1992) has argued perhaps not without cause that the name gives no indication of the significance of the harm to self and others. Taylor (1992) clearly did not approve of the comedic aspect, albeit Doctors have contributed to this. What is remarkable about this correspondence, however, is the strength of feeling about an obscure historical figure, the importance of whom, has clearly been lost in time.

So, for example, Wingate (1951) wrote to:

protest on behalf of the great Baron Von Munchausen, who was far too wise a fool to have put himself in peril of having to undergo an abdominal operation (p412).

Jelly (1957) wrote in admiration:
.... Why this very military and wholly admirable character should be degraded in this way, I cannot understand, nor why these miserable psychopaths should ever have been granted such a distinguished forbear (p1124).

JAMA (1974) published a letter as part of an Editorial 20 years later from Dr Vaisrub, a German contributor:

'Those, who know where he lies buried and are privileged to live nearby should not be surprised if they hear him turn in his grave every time his name is mentioned eponymously'.

Some early correspondence to the BMJ does also comment on the derogatory nature of the title to patients (Barker and Lucas 1965). Later writers also comment on its vindictive connotations (Stone 1977). Other correspondents supported the name as capturing the essence of Munchausen Syndrome (Howe et al 1983 in Fisher 2006), presumably in reference to the telling of false stories to Doctors. Objections were raised to its unscientific nature (London 1968). Purely for descriptive reasons, various other names were offered as alternatives. Spiro (1968) suggested Chronic Factitious Disorder, later came Artefactual illness (Carney 1980), Ipsepathogenic

Patients (Marsh and Johnson 1983) and nosocomotropism (Gorman and Winograd 1988).

The Psychiatric Classification of Munchausen Syndrome

Munchausen Syndrome is not a DSM term. Not officially categorised until 1980 (DSM III 1980), MS is labelled more generically under the broader heading of Factitious Disorders, specifically recognised first as *factitious disorder with physical symptoms* with sub-categories of *psychological symptoms* or *not otherwise specified.*

The 1987 revision to the DSM III provided and clarified the central features of intentionality and motivation. The motivational aspect of '*to assume the sick role*', which differentiates MS from malingering or other motives for secondary gain e.g. money, emerges here. This will, however, come to engender later definitional issues, in respect of the '*by proxy*' motivation in Msbp child abuse.

There are likewise less generous descriptive labels; *hospital addiction, hospital hoboes* and *peregrinating patients*, predominantly from the earliest case notifications. Munchausen Syndrome remains the most widely used. Problems in the use of *syndrome* have been widely noted Mart (2002) in terms of clinical validity. Similar concerns have been raised, by extension, in respect of Msbp.

Munchausen Syndrome becomes Munchausen Syndrome by Proxy.

As in the case of Munchausen Syndrome, Munchausen Syndrome by proxy has had many names and permutations often to be rid of the 'Munchausen' component and its link with the Beverley Allitt case. Baldwin (1996) has suggested that the link is now forever made with serial murder. Historically, terms such as *Polle Syndrome* (son of Baron Munchausen who died in infancy), *Meadow's Syndrome, Doctor shopping* and *Masquerade Syndrome* have been put forward.

Practical diagnostic concerns have frequently been reflected in and overlap historical concerns about terminology. These primarily have drawn attention to: a lack of clarity as to what and to whom the term should be applied. In a set of very significant papers published under the banner of '*Controversy*' in the Archives of Disease in Children (1995), Morley complains about the lack of specificity of the terminology in terms of not clearly describing what has happened to the child, as well as, being too broadly encompassing of the range of behaviour, under the Msbp heading, which mothers (parents) might manifest. Morley (1995) raised particular objections to *exaggeration* being considered Msbp, *since lots of mothers do it without any malignant desire to mislead' (p529).* Information such as: The baby hasn't eaten in days and is sick all the time ..... she'll cry all day' is more akin to a linguistic device of emphasis rather than attempts to mislead. All professionals are familiar with this style of imparting information during history-taking interviews.

Fisher and Mitchell (same series 1995) provide one of the most comprehensive summaries of all that is controversial about Msbp. They argue for the abandoning of the term Msbp except when there is clear evidence of MS in the perpetrator. They favour terminology, which *describes* what has happened to the child, based on case-history and examination, rather than through a label with embedded assumptions about a diagnosable disease and a specific psychopathology. For example: factitious or induced apnoea, factitious epilepsy etc. This makes the roles of and medical duties of the psychiatrist and Paediatrician clear albeit demarcated, as well as delineating aspects of child abuse. Echoes of this paper are to be clearly heard in the subsequent literature (RCPCH Guidance 2002, Rosenberg 2003).

In a series of papers, American Psychiatric Association (APSAC 2002), Ayoub et al have suggested that *Paediatric Condition Falsification* (PCF) be used to describe maltreatment through illness falsification (Msbp) and a child subjected to the

treatment as a victim of PCF. They retain the DSM IV (1994) label of Factitious Disorder by Proxy (FDP) for the perpetrator.

The Royal College of Paediatricians and Child Health (RCPCH) Working Party Report (2002) recommends that *Fabricated or Induced Illness (FII)* is adopted as the preferred term as does the Department of Health (DOH) Guidance, which was drawn up within the framework of *Working Together To Safeguard Children* (Department of Health,1999). In spite of this, there remains a lack of consistency, in terminology, with most Paediatricians both here and abroad, continuing to use *Munchausen Syndrome by Proxy* (Rosenberg 2003, Sheridan 2003 USA; Bortsch et al 2003, Germany; Eminson and Jureidini 2003 GB/AUS).

In a recent paper, Eminson and Jureidini (2003) have considered the problems and benefits of labels. They suggest that the term Msbp draws attention to child abuse and that the medical system is involved as well as the need to plan for a child's safety and to halt further unnecessary medical intervention or treatment. However, labelling a parent as a *perpetrator* of Msbp does not advance the cause of the child, in terms of describing the harm or its impact. Nor does it guide future professional in-put to the child in terms of psychological support.

Fisher and Mitchell's (1995) preference for describing the abuse in terms of what has actually happened to the child and what can be evidenced by Doctors (eg factitious epilepsy) is recognised in the literature, in principle at least, if not actually adopted as terminology and would be the preference here: however, to achieve consistency and more especially to avoid confusion in the reader, Msbp continues to be used throughout this thesis in spite of its own arguments against it. It is to be anticipated that this terminology will persist as long as the professional literature remains inconsistent.

The Definition of Msbp Child Abuse

The last section dealt in a rather quirky way with issues in respect of terminology. Jill Fisher's (2006) paper has described the processes, by which the narratives told *about* and *through* Munchausen Syndrome came to create meaning among Doctors. The recursivety of cases, described by Allison and Roberts (1998), extended the narrative further and provided a means of constructing patients, rather than the illnesses they presented with. The 'Story' of Leo Lamphere (Chapman 1957) represents a case in point.

This historical trend also saw Doctors accepting a pattern of concurrence of behaviours, characteristically simulation and deception, as constituting a medical syndrome, without raising objections, on the grounds of clinical validity (Allison and Roberts 1998). The historical medical literature is remarkably quiet in this respect.

Issues in respect of definition, in particular what motivates a mother to falsify illness in her own child, in a distorted interaction with the medical system and whether she herself is sick, preoccupies the literature. This, in combination with the shifting grounds of terminology, constitutes the burden of understanding Msbp as child abuse.

Msbp encompasses many situations, in which children can be presented as ill, not due to a disease or external cause, such as an accident. At one level of interpretation, this represents the abuse of a child at the hands of a parent, which provides immediate and long-term sequelae, in the form of permutations of physical and psychological outcomes. The early case-series associated Msbp with other dangerous forms of physical harm and abuse: Smothering (Southall et al 1997, Meadow 1990, 1996) and non accidental poisoning (McClure et al 1996). Often to produce physical and dramatic symptoms in a child, these forms of acute

presentation represent the most dangerous manifestations of Msbp resulting in death or severe neurological impairment.

As noted above, concerns have been expressed that *exaggeration* should not be considered Msbp (Morley 1995, Mart 2002) being natural linguistic embellishment, rather than emerging from a malignant intent. Although there is no new research evidence indicating a trajectory from exaggeration to fabrication, the work of Bools et al (1992) indicates that both forms can operate contemporaneously, in combinations of exaggeration and falsification and has provided evidence which indicates that there is a significant level of co-morbidity in cases of Msbp, involving other forms of harm to the index child and siblings. This points in the direction of constructing Msbp, within wider systemic formulations of child abuse, particularly since there is evidence that the mother may not be solely focussed on one child as victim and may be harming different (or the same) child, in a variety of ways.

There are decided benefits in models such as that advanced by Eminson and Postlethwaite (1992, 2000), which recognise the dimensional nature of parental concern for their children's health ranging from severe neglect to gross over-involvement and which provide for an overlap with more commonly found forms of physical harm. Eminson and Jureidini (2003) have recently agreed that this type of approach has drawn attention to alternative ways to account for parental behaviour, which are more appropriate '*than categorical and diagnostic formulations*' (p416). Those, who advocate a narrow conceptualisation of Msbp based on the need to understand *motivation* (Meadow 1995, 2002, Schreier 1993, 2002), do so in recognition of the dangerousness of this form of abusive maternal behaviour. Meadow above (1995, 2000, 2002) and in collaboration (Bools et al, 1994) has maintained this position. Schreier (1993, 2000, 2002) is equally consistent.

The historical review (Chapter I) began by examining how medical systems and Doctors, by the very nature of what they can provide – all aspects of care, nourishment, shelter, succour, attention, *avoidance excuses*, drugs (and the list goes on) are familiar with the continuum of psycho-physiological disorders, which lie at the difficult junction between the psychological and medical meaning of illness – of being ill. This brings patient and Doctor together in a collaborative process: part of the Doctor's skill and duty is to determine the level of intentionality and volition that the patient exerts in the condition. Taylor (2000) has described this in terms which emphasise how visible this type of illness requires to be; he refers to it as a '*public performance of being sick*'.

Msbp appears to reflect a maternal *script* resulting in the public performance of being a mother with a sick child. This imbues her with a particular status guaranteeing attention, particularly when a child is presented acutely. (Professor Minns personal communication). Mothers who are subsequently detected, tend to be described in terms which emphasise duplicity, while strongly underlining the breach of their maternal role and duties to the welfare of their child. They have been constructed as medical impostors. (Schreier and Libow 1993).

Motz (2001) draws attention to how this subtle reframing alerts us primarily to the perversion of the female role and diverts focus away from acts of child abuse and culpability. Doctors work within a framework of assumptions about mothers and children so that there is an inability or reluctance to accept that women, or women as mothers, do harm to their children, which can delay Msbp being factored in as part of the differential diagnosis (Parnell and Day 1998).

In a very simple summary, Eminson and Postlethwaite (2000) have articulated the core 'ingredients' of Msbp as a triad. **They do not represent definitional criteria:**

1. A health care system, in which Doctors, nurses and other health care personnel have almost unlimited capacity in terms of resources and technology to undertake investigations and interventions with children.

2. A dependant child is available for a parent (or person *in loco parentis)* and is under his or her control, influence or behest.

3. A parent, or person *in loco parentis*, presents the child to the health care system with invented symptoms or fabricated signs.

The RCPCH (2002) has more recently, described this triad as '*duped Doctor, harmed child and fabricating parent'.*

While these represent the core 'triad', lack of recognition and early identification, combined with a systemic paralysis in child protection services due to the fear of litigation, contributes to the maintenance of children in abusive situations longer than necessary. Certain high profile cases, evidencing the professional and personal costs have exacerbated this effect. While this might be said of any child abuse scenario, Msbp cases have a higher than average litigation rate (Eminson and Postlethwaite (2000).

Two main strands to defining Msbp will be reviewed here. For the purposes of organising the literature it is separated into broad categories: *definition by motivation and definition by harm* (Eminson and Postlethwaite 2000). The problematic nature and pitfalls inherent in *behavioural profiles* or *diagnostic pointers* (Morley 1995) will be discussed, also. These are clumsy distinctions, serving practical purposes. There is no conflict in the professional literature: the

child's welfare is paramount. However, there are different emphases and there are very important and central contributions to the literature, which have consistently drawn attention to the need to account for maternal behaviour and motivation in frankly psycho-pathological terms, and to differentiate Msbp from the more usual forms of child abuse encountered by Doctors and Child protection agencies (Meadow 1995) (Schreier 1993, 2002). This approach has largely been influenced by research evidence of the dangerousness of women, who harm children through the grossest forms of physical fabrication and tampering (Meadow 1999, Bools et al 1994, Southall et al 1997).

The literature is more ambivalent in cases of Msbp where there is no physical abuse and has led to speculation about where on the spectrum of harm might maternal behaviour be classified as Msbp. Some Paediatricians restrict this form to the more serious induction/fabrication cases (Meadow 1995, 2000). These are noted here as major questions permeating the literature, which essentially relate to wider, more fundamental issues, in particular, clinical validity. Mart (2002) has drawn attention to a lack of any available analysis of co-variance in the research literature, which would permit comparison groups (e.g. mothers who have engaged in physical abuse of children in non-hospital settings with mothers who have engaged in physical abuse of children in hospital settings). This would provide information about features of similarity, dissimilarity and overlap in terms of maternal functioning and the pathways leading to acts of abuse.

There are better ways of describing parental abusive behaviour other than using medical classifications and terminology (Eminson and Jureidini (2003). Recent RCPCH Guidance (2002) has avoided being partial on the issue of maternal *psychopathology* and *motivation* as well as what it refers to, as *semantic* issues in respect of terminology.

This likewise recognises the dimensional nature of Doctors responses to parental concern about children on a continuum '*from being dismissive at one end to excessive intervention and treatment at the other*' p18 acknowledging iatrogenic harm to children both in cases of Msbp and in its absence. It states:

> '*The assumption was that the Doctor had an objective reasoned proportionate appraisal. This is not always so. Both Doctors and patients can be off the mark. (p18).*

Definition by Motivation

Meadow's (1977) recognition of perverse maternal behaviour in paediatric settings, and illness falsification, in one case, by inducing symptoms, through salt ingestion and in the other, fabricating the signs of illness to prompt medical attention and intervention to the children's harm, caused him to make the link to similarities with the adult psychiatric diagnosis Munchausen Syndrome. This came to embed a form of child abuse within adult psychological disfunction shrouded in the problematic connotations of *motivation*. Meadow (1977) provides no explanation of how the two are linked beyond similarities based on behavioural observations and speculations as to motivation and purpose.

The influence of this paper, in combination with a conference presentation of the early cases (Annual Meeting: Paediatric Association 1980) and the publication of case series (Meadow 1982) prompted further cases to be written up in the professional literature. In a response similar to that following Asher's 1951 paper, Paediatricians, anxious to demonstrate examples of what Meadow (1995) will later describe as '*the weird, calculated or manipulative ways, in which a parent has harmed a child*' (p595) contributed to what Allison and Roberts (1998) will later describe as '*the Munchausen litany* ' This evolved out of this period of matching cases to the explanatory and descriptive profile, provided in the 1977 paper.

The early papers are generally single case notifications cataloguing abuse manifestations, concerned less about the process involved. Perhaps understandably, some at least of these early cases, demonstrated '*diagnostic errors*'. Among this group are to be found cases of what Rosenberg (2003) will later refer to as *overcapture* (cases with poor or no evidence of Msbp, *undercapture* (cases hesitantly or not recognised as Msbp) or *logical flaws* (no Msbp or perhaps genuine illness, which can accompany Msbp). Doctors were frequently drawn to the diagnosis having reached wrong conclusions about maternal behaviour.

As in the emergence of Munchausen Syndrome, the early recursive professional literature will establish Munchausen Syndrome by Proxy, albeit with a lack of clarity as *to what* and *whom* it applies. Issues will be raised later with regard to clinical validity and the syndrome status of Msbp (Mart 2002, Fisher and Mitchell 1995) whether it is a paediatric or psychiatric conclusion (Fisher and Mitchell 1995) and the correct inclusion of cases (Meadow 1995). There is no evidence, however, of any critical evaluation of either a medically or psychologically conceived Munchausen Syndrome. (Allison and Roberts 1998) as providing its origin.

The first *definition* emerging from the work of Rosenberg's (1987) meta-analysis of 117 cases in America, reflects the sharp end of Msbp presentations (i.e. physical harm) and contemporary case experience. Diagnostically more subtle and often problematic presentations, involving psychological presentations of Msbp will emerge later in the literature (Schreier and Libow 1993, Schreier 2000). The later inclusion of cases of sexual abuse remains controversial, since these are likely to involve different behaviours and motivations, particularly if used in custody battles.

The *Syndrome Cluster* is defined by Rosenberg (1987) as:

1. Illness in a child, which is simulated (faked) and/or produced by a parent or someone who is *in loco parentis*;

and

2. Presentation of the child for medical assessment and care, usually persistently, often resulting in multiple medical procedures;
and,

3. Denial of knowledge by the perpetrator as to the aetiology of child's illness;
and,

4. Acute symptoms and signs of the illness abate when the child is separated from the perpetrator.

Although Rosenberg (1987) excludes physical abuse, sexual abuse and non-organic failure to thrive, when occurring alone, she notes difficulties in differentiating between other forms of abuse or abnormal illness behaviour in parents for their children: intentional poisoning, infanticide, pathological Doctor-shopping, extreme parental anxiety or thought disorder. Rosenberg's (1987) diagnostic cluster will later be challenged on the same grounds of lacking specificity (Meadow 1995, Morley 1995).

Meadow's (1995, 2002) consistent position has been to emphasise that understanding maternal motivation is the key to differentiating Msbp from other forms of child abuse, which effectively separates his criteria from Rosenberg's (1987) and that Msbp is a label describing the abuse to a child rather than a label for the perpetrator. The label makes clear that the motivation is '*to assume the sick role or another form of attention seeking behaviour*', which is broadly in keeping with the DSMIV (1994) and DSMIV T-R (2000) American Psychiatric Association classification of Factitious Disorder by Proxy (FDBP) as described below: although used to refer to the perpetrator.

Meadow's criteria (1995) set out to address the lack of specificity of those proposed by Rosenberg (1987), purposefully differentiating a homogenous group of perpetrators and preventing overlap and the inclusion of cases better categorised as: failure to thrive and/or neglect, over-anxious parents, mothers with delusional disorder, Masquerade Syndrome, hysteria by proxy, Doctor-shopping and mothering to death.

More recently, in response to the DSM IV text revision, American Psychiatric Association (2000), Meadow (2002) has recently highlighted key issues of concern. He suggests that as a label for the perpetrator as opposed to the abuse, the DSM IV T-R (2000) criteria fail to exclude cases of prolonged undetected physical abuse. He also suggests that external incentives and gains (benefits, child care allowances etc) should not exclude Factitious Disorder by Proxy (Msbp) since the financial gains can be considerable and parents come to rely on them. As a consequence, retaining benefits can be a powerful incentive to continue the abuse. For the purposes of comparison both sets of criteria are provided here:

DSM IV T-R (2000) (Research Criteria)

A. Intentional production or feigning of physical signs or symptoms in another person who is under the individual's care.

B. The motivation for the perpetrators behavior is to assume the sick role by proxy.

C. External Incentives for the behaviour, such as economic gain, are absent.

D. The behaviour is not better accounted for by another mental disorder.

Meadow's Criteria (2002)

1. Illness fabricated (faked or induced) by the parent or someone in loco parentis;

2. The child is presented to Doctors, usually persistently; the perpetrator (initially) denies causing the child's illness;

3. The illness goes away when the child is separated from the perpetrator;

4. The perpetrator is considered to be acting out of a need to assume the sick role by proxy or as another form of attention seeking behaviour.

It is something of a paradox but there is evidence from Meadow's own work and in collaboration that parents, predominantly mothers, who fabricate illness in children, do *not* represent a homogenous group of perpetrators. Meadow has recognised that the seeking of a single motivation is '*simplistic*' and that '*complex behaviour is likely to result from complex motivation*' (Meadow 1995 p537). While collaborative research may have highlighted a range of psychological difficulties to be located in perpetrators (Bools et al 1994) these likewise do not combine to form a homogeneous group, marked by a distinct psychopathology and might be found as occurring equally in clinical and non-clinical populations.

Looking at the totality of Meadow's work the significance he places on differentiating out a homogenous group of perpetrators is to be understood in reference to his emphasis on the need to identify adults, who have personal abnormal illness behaviour for themselves as representing a potential danger to their children. In the event of Msbp abuse, the presence of evidence of adult abnormal illness behaviour ratchets up concern for any dependent child(ren). In turn, this would be particularly the case in women, who fabricated illness in children, at the sharp end of

physical harm, in hospital settings. Meadow (1995, 2000) sees this group as representing a particular level of dangerousness to children. He suggests that this should guide child protection work in the event of separation and later family rehabilitation and therapeutic in-put post discovery.

Rosenberg (2003), recognising problems in correctly recognising and diagnosing Msbp, has reconfigured the main elements of her own and Meadow's criteria, absent any motivational component, to provide sets of diagnostic criteria matched to different levels of diagnostic certainty. Rosenberg's approach draws attention to the use to be made of the key definitional components, in arriving at a conclusion, without the need to account for motivation, as indicative or proof of child abuse: this she sees as logically flawed. She argues that, to be included as a diagnostic criterion, each aspect should be observable: since intent is inferred and not observable, it cannot be include as a diagnostic criterion.

The issue of *motivation* remains contentious. Schreier, alone (1996, 2000) and in collaboration with Judith Libow (1993), has advanced psychodynamic interpretations of Msbp. In their ambiguously titled work 'Hurting For Love' Schreier, in particular, offers formulations of maternal motivation to harm through illness falsification around theories of transference. Briefly put, a person (in this case a woman) satisfies unresolved needs for psychological approval and nurturing through contact with a powerful male (father substitute) figure. Or, as the authors suggest - for the first time in a women's life, someone shares her emotional space, valuing her opinions and listening to her.

Schreier shares Meadow's view in respect of the need to understand motivation but recognising that this is likely to go beyond *only* those relating to seeking attention *by assuming a sick role* by proxy. Schreier (2002) is clear that his would not explain the extremes of attention seeking experienced in some high-profile cases, particularly in America.

Writing with specific reference to a 'high-profile' American case (Kathy Bush) Schreier (2002) underlines the importance of understanding wider *motivation* in differentiating Msbp from other forms of child abuse, particularly in the legal arena. Any evidence, in the absence of evidence of motivation, becomes purely circumstantial. Both Schreier (2002) and Meadow (1995, 2000) are concerned to differentiate perpetrators, if anything, by their dangerousness to children. While this is an important observation, it is difficult to conceive of any lay-jury able to understand how this group of mothers differs from those, who physically abuse children. In legal terms, establishing the motivation to harm might be important but has little value in establishing a paediatric conclusion of child abuse, which should be evidenced by the physical harm to the child. Rosenberg (2003) has made clear the problematic use of definition by motivation, which is an inferred aspect of Msbp. She notes that physical abuse *absent* any clear definition of maternal motivation remains just that: all is not dependant on knowing motivation. Definition by *motivation* is unique to this form of child abuse.

Psychodynamic explanations of Msbp are not endorsed here. Models describing problematic mother-child attachments and problems in wider aspects of psycho-social functioning, both for the individual alone and within the family, are considered as potentially more useful in describing the origins and maintenance of Msbp child abuse. The need to root explanations of personality development within a particular and historical social context and culture are also recognised by Schreier and Libow:

> *'if we have learned anything in the realm of personality and development and disorder it is that no individual form of psychopathology can exist or be understood outside of the social-psychological context in which it is found' (Schreier and Libow 1993 p 82).*

Hurting For Love (1993) occupies a fairly unique position in the psychiatric literature in offering explanations of *motivation* derived from theoretical perspectives on the development of psychopathology rather than inferences about motivation derived from hospital observations or *confessions* (Meadow 1995). To this extent, as a work, it parallels the contribution of Menninger (1934) and his theoretical perspective on *'poly-surgery and poly-surgery addiction'*. The work of both authors, separately, and in collaboration, elsewhere, has gone on to provide very important contributions to understanding Msbp. The influence of psychodynamic theory, it has to be said, is not immediately available from reading the professional literature.

The Psychiatric Diagnosis of Munchausen Syndrome by Proxy

Problems in the use and understanding of terminology and whether Msbp is a paediatric conclusion or a psychiatric diagnosis is maintained by its inclusion within the psychiatric classification system. The use of the more generic term Factitious Disorder by Proxy references the psychiatric diagnosis of Munchausen Syndrome as one of a number of conditions listed in the classification system broadly termed *'mental disorders with persistent physical complaints'* (Mart 2002). This describes disorders, in which physical complaints are variously affected by psychological factors. Somatising disorders at one end of the spectrum will include malingering and Munchausen Syndrome, classified in the 1980 (DSM III American Psychiatric Association) as Factitious Disorder (with physical symptoms). Factitious Disorder (with psychological symptoms) is noted in the diagnostic criteria but was thought to occur less commonly (Feldman et al 1994). Jones (1992) has described cases of factitious psychosis.

The 1987 text revision (DSM III T-R American Psychiatric Association) clarified the central feature of *intentionality* and *motivation* required to make a differential diagnosis of Factitious Disorder. What will later constitute difficulties for the future

definition and understanding of Msbp originate from this text revision, which clarified motivation in Factitious Disorder as: *to assume the sick role in the absence of secondary gain* i.e. malingering.

Munchausen Syndrome by Proxy is first recognised in the DSM IV (1994 American Psychiatric Association). There are two main acknowledgements: F68.1 *Factitious Disorder Not Otherwise Specified and Research Criteria.* The most recent DSM IV Text Revision (American Psychiatric Association 2000) leaves the position relatively unchanged.

The International classification of Diseases (ICD 10 WHO 1992), which is a descriptive system, differentiates between perpetrator and victim. While the term factitious illness might be used to describe the perpetrator if this is appropriate, there is no assumption made as to psychological content. Harm to a child is coded descriptively on an Axis One diagnosis (for example: hypernatraemia) and on an Axis for coding of maltreatment. This emphasis clearly highlights the physical harm to the child of acts of child abuse devoid of motivational aspects.

The main concern about the psychiatric classification of Msbp/FDbp is that it assumes a link with Munchausen Syndrome/Factitious Disorder that is causal and that both share similarities, which is not borne out in the research. The literature does not support there being a uniform history or trajectory leading to Munchausen Syndrome by proxy so that one would appear to be subset of the other. It likewise assumes a one dimensional explanation (through motivation), whereas a range of psychosocial and ecological factors are likely to provide '*the setting conditions*' for fabricating illness both in oneself and in a child (Eminson and Postlethwaite 2000). Not enough is known about Msbp to assume the same dynamic formulation or motivation (Parnell and Day 1998).

The preponderance of women as perpetrators (Rosenberg 1987) points in this direction, particularly towards problematic attachment behaviour (Jones 2000) as well as to psychological difficulties in themselves. Mothers have certainly been shown to exhibit signs of Munchausen Syndrome prior to, and subsequent to, the removal of children, as a result of Msbp abuse (Schreier and Libow 1993).

Categorical systems do not recognise different entry or stop points: nor do they recognise the range of maternal behaviours leading to providing inaccurate medical histories for children, mainly harmless. Evidence based criteria are less likely to be encumbered by these limitations.

The Problematic Nature of Motivation and Behavioural Profiling

There are problems inherent in defining any behaviour by *motivation*. Those which are inferred are problematic by being subjective and potentially inaccurate post hoc rationalisations (Eminson and Postlethwaite 2000). Those available from perpetrators of Msbp are likely to be unreliable by the very nature of the main protagonists capacity to mislead. Motivation may vary and change overtime. There is widespread agreement that child abuse should be described by the very acts of abuse and not by motivational definitions based on inferred intent (Rosenberg 2003).

Not enough is known about the trajectory of abuse and whether different types of fabrication equate with different motivations. There is little agreement about motivation in lesser forms of Msbp and where on the spectrum of harm might it be said the Msbp begins. Morley (1995) has argued that *exaggeration* should not be considered Msbp. Yet, the outcomes for a child from exaggeration may produce indirect harm through unnecessary medical interventions and procedures.

That there is a *homogeneous* group of mothers whose sole motivation is '*to assume the sick role*' is not supported in practice (Eminson and Postlethwaite (2000). Kelly

and Loader (1997) have advanced definitions recognising a broader spectrum than previously recognised, beyond '*the classic one of the carers need to take on the sick role by proxy*' (1997 p122). Information from the victims of Msbp point to more complex underlying pathologies between parent and child and on to difficulties in attachment, as argued throughout.

Msbp has historically been defined by motivation and by assumptions as to intent inferred from observed behaviour. Allison and Roberts (1998) have observed that both sets of information are now inextricable. This is likewise evident from proposed diagnostic criteria (Meadow 1995, 2000) Rosenberg (1987).

Meadow (1994) and Samuels et al (1992) have also provided influential '*diagnostic pointers*' to alert Paediatricians to the possibility that Msbp may account for symptoms in a child. These have been widely criticised as being *non specific* and as providing questionable evidence of culpability or intent (Morley 1995).

In reference to Meadow's (1995) criteria – and presumably those also of Rosenberg (1987) – Morley (1995) has argued that mothers may naturally exaggerate symptoms to alert Doctors to a child's illness. The same level of anxiety, or a lack of any improvement may result in a child being over-presented. He suggests also that the possibility of genuine illness cannot be ruled out, thereby resulting in frequent visits to the Doctor or hospital and that the denial of any knowledge of the abuse may represent *innocence*. Perpetrators of child abuse tend to deny all knowledge. It is of concern if there is evidence supporting Morley's (1995) claim that some mothers may '*confess*' in order to have a child returned to them. This is reminiscent of the mechanisms of religious and political witch-hunt trials, or, as Mart 2002 points out '*an affirmation or a denial ... . would indicate the presence of Msbp' p50.* Finally, Morley raises concern about temporal associations. He has noted that some illnesses get better naturally with time and that reception into care may coincide with this.

Morley's (1995) concerns relate predominantly to the consequences of poor history-taking and interview skills, leading to the wrong conclusions about the symptoms themselves and the mother's intention. Nor can a lack of any clear diagnosis be always associated with or indicate falsification. This view is endorsed by the RCPCH Guidance (2002):

'Uncertainty of the origins of a child's symptoms is not rare. One review showed that 9% of inpatients and 24% of out patients were discharged without a confirmed abnormality. Some genuine disorders whether physical or psychological have no objective physical signs, no definitive investigations and are often multifactorial. (RCRCH Guidance (2002) p18).

Mart (2002), who has devoted a text to the analysis of the evidence-base for Msbp, has argued that behavioural and psychological profiles are weak and vulnerable indicators with poor predictive validity. This relates to their nature as being broad descriptors. Citing the work of Rappaport and Hochstadt (1995) and the influential profile provided by Schreier and Libow (1993), he demonstrates their inherent short-comings not least that there is an enormous difference between problematic parental behaviours and Msbp. He suggests that none of the typical Msbp behaviours has been reliably related to the presence or absence of Msbp nor has the base rate been established of these behaviours, in parents of chronically or seriously ill children when Msbp is not an issue (p50). Nor can behaviours or illnesses (psychopathology), prevalent in the general population, be taken as *indicators.* Essentially, Mart (2002) argues that we do not have the research evidence to differentiate between the behaviour of the parents of chronically sick children and that of perpetrators of Msbp. He has suggested that an analysis of co-variance would clarify areas of similarity and dissimilarity.

Cases of illness induction or those referred to as '*mixed forms*' (Bools et al 1992) and *lesser* forms e.g. exaggeration, suggest that perpetrators are unlikely to be characteristically uniform and will represent different levels of risk to children.

Problems in the correct identification of Msbp have not been minimised by recent RCPCH Guidance (2002) on Fabricated or Induced Illness by Carers (FII). The Guidance (2002) provides for the definition of FII as child abuse and as a *paediatric conclusion* evidenced by harm done to a child rather than a conclusion arrived at through inferences as to intent or to psychiatric definitions of motivation. This partial view makes clear the professional role of Paediatricians and to this extent is an important one. Its reference to *'predisposing characteristics'* and *'risk factors'* leading to abuse approximates to systemic interactional models of behaviour, which offer the best hope for describing and understanding the dynamics of child abuse in its various forms. The Guidance has responded to concerns about the usefulness of explanatory models of child abuse embedded in models of motivation and adult psychopathology.

This being said, in an effort to avoid a narrowly defined *homogenous* group akin to that specified by Meadow (1995) the Guidance (2002) identifies *warning signs* which have identified an overly heterogeneous group of maternal behaviours, very loosely bound together through the presentation of children to Doctors. Although referred to in the Guidance as *'warning signs'* they combine to produce an array of scenarios, which lack the specificity to be of any real use. They have little or no predictive value and overlap other manifestations of child abuse. It also remains unclear as to what they are warning signs of, since there is no evidence in the literature to suggest an escalating trajectory of harm (Eminson and Postlethwaite 2000). Although avoiding issues in motivation, the Guidance (2002) adopts Meadow's 1995 *diagnostic criteria* (below) into the body of their own definition. They note criterion 3 and 4 as being applicable to other forms of abuse:

1. Illness in a child which is fabricated by a parent, or someone who is in *loco parentis*.

2. The child is presented for medical assessment, often resulting in multiple medical procedures.

3. The perpetrator denies the aetiology of the child's illness.

4. Acute symptoms and signs of illness cease when the child is separated from the perpetrator.

(Meadow 1995)

Meadows criteria are referenced below as '*all forms of such activity*'. The RCPCH Guidance (2002) states:

> *Fabrication or illness induction includes all forms of such activity and do not inevitably clarify the motivation of the carer, which may be difficult to ascertain. It can include the old terms Msbp or Mbps whether applied to carer, child or scenario and includes delusion, excessive anxiety, masquerade, hysteria, Doctor-shopping, Doctor addicts, smothering to death, seekers of personal help or attention or financial gain, and those who fail to give needed treatment as well as those, who treat unnecessarily.*
> (RCPCH 2002 p9).

The problems inherent in warning signs/behavioural profiles used as *diagnostic pointers* based primarily on anecdotal professional observations have already been described above. (Morley 1995, Mart 2002) and are pertinent here.

None of the behaviours described in the Guidance (2002) can reliably be taken to indicate the presence or not of Fabricated or Induced Illness (their preferred terminology). They raise questions as to what constitutes a worrying parental behaviour and at which point does this cross the threshold into significant harm, however that is defined.

The Guidance (2002) does not recognise that parents will present innocently, at different points on the spectrum of parental seeking of health care for children, some of whom may have a genuine (or undiagnosed) illness. The parents of chronically sick children will quite characteristically '*Doctor-shop*' to track down an

explanation or, in vain hope of improvement or a cure. It is difficult to see how *excessive anxiety* per se can be reconciled with a conclusion of Munchausen Syndrome by proxy never mind Fabricated or Induced Illness which has very specific connotations of direct physical harm to a child by a parent.

The '*warning signs*' aimed at differentiating *normal* from *abnormal* parental behaviour and at differentiating between forms of child abuse are too generalisable, by their very nature. This is perhaps being deliberately obtuse since all professional working with children and families recognise what working with an excessively anxious parent *feels* like, as would they recognise the personal discomfort of the request for a second opinion. However, it makes the point that we are not in the business of *feelings* but *evidence*.

Financial gain has always been contentious; excluded from the DSM IV (1994) definition, Meadow (2002) has recently acknowledged that some parents become so accustomed to the income from benefits awarded to children with illness (Disability Living Allowance) that it becomes difficult to alter abusive behaviours so that the child returns to health. Most professionals working with children, broadly defined by *special needs*, will recognise a D.L.A. claim form when s/he sees one, while often failing to recognise the child beneath the embellished descriptions of their needs provided by their families. Some at least of these, may be acting out of poverty.

Diagnostic criteria have been combined with '*early warning signs*' without any theoretical underpinning as to how they are linked or, more relevantly, may vary. This is evident from the over-inclusion of different types of abuse, likely to have different pathways. A parent with-holding treatment neglectfully or carelessly from a child, will require a different management approach from a mother deliberately doing the same to exacerbate symptoms to gain medical attention. While both might constitute harm to a child and have their origin in problematic attachment, the

reason(s) why one mother chooses to ignore her child's needs, while another mother chooses to use her child as collateral to fulfil a psychological need, has to be understood in order to provide a focus for intervention work and to provide for the welfare and safety of the child.

DEFINITION by HARM

The problematic nature of definitional models based on motivation and behavioural profiles have been described here and in the literature (Morley 1995) Fisher and Mitchell (1995), Allison and Roberts (1998), Mart (2002), Rosenberg (2003). Eminson and Postlethwaite (1992, 2000) have provided ways of describing parental behaviour, which takes account of the spectrum of parental abnormal illness and consultation behaviour, while avoiding psychiatric categorisations. Their formulation demonstrates the dimensional nature of parents need to consult Doctors for their children and that these represent a mixed set of behaviours, ranging from harmless to harmful.

Difficulties in defining what constitutes harm and where the threshold lies are acknowledged as being particularly problematic the further one travels from clear physical evidence of direct harm (through hands-on tampering) or from the iatrogenic harm arising from falsified signs or histories, Eminson and Postlethwaite (2000). Models roughly bound together by a framework of '*definition by harm*' are described below.

One of the first models describing the spectrum of health seeking behaviour by parents on their children's behalf is provided by Waring (1992). He advanced a '*persistence algorithm*' which matched parental persistence in seeking medical consultation to the child's need for health care. Waring's model recognises a

spectrum of behaviours, by parents, on behalf of their children both in cases of children where organic disease is present and where it is not or psychogenic in origin. Where there is a lack of 'congruence' between parent and Doctor, other diagnoses or possibilities need to be considered, such as anxiety in the parent, exaggeration or malingering to direct induction of symptoms and Msbp.

Models such as that provided by Fisher (1995) offer a developmental and systemic framework for explaining abnormal illness and consultation behaviours in parents. He suggests that these have their origins in a constellation of psycho-social and intellectual risk factors in early childhood, which act on personality development . These have persistent effects, often further scaffolded by subsequent experiences to provide a cumulative effect across the life span. Children entering the health care system with parents possessed of what Fisher (1995) refers to as '*predisposing factors*' may be rendered vulnerable to being over presented or, in extremis, to illness induction.

Fisher's (1995) model recognises that a variety of 'triggers' might escalate or precipitate harm to a child. This is an important observation, which is also one of the strengths of ecological developmental models of child abuse, otherwise they might be overly deterministic. This recognises that the vulnerability of children to being harmed by parents, in all forms of child abuse, waxes and wanes and is more likely to be dependant on intervening factors, which are either *compensatory* or *potentiating* (Jones and Ramchandani 1999).

Fisher's model (1995) provides for the integration of variables across the life span of the child within the family and identifies factors, which predispose carers towards harming children, and which later, alone or in combination with other intervening variables, sustain and perpetuate the behaviour (Jones and Ramchandani (1999).

This model is in keeping with accepted frameworks for describing non-Msbp child abuse. Understanding the contexts of abuse and what potentates it is important at the *macro* level in informing child protection policy but has greater, more immediate significance, at the level of individual case-work, in influencing decisions about level of risk, which a child may be being exposed to and the type of intervention or support required to keep that child safe.

The model advanced by Eminson and Postlethwaite (1992, 2000) (Figure 1) recognises that parental behaviour in respect of seeking consultations and health care for their children is dimensional. They identified three broad groups of parents roughly defined by their ability to differentiate their own needs from those of their child's. Areas of potential child abuse were marked by the extent of the discrepancy between the parent's behaviour and an objective view of the need to consult. Represented diagrammatically as a spectrum, of what Eminson and Postlethwaite refer to as *parental competence* from classical neglect through ignoring or undertreating symptoms to fabrication of symptoms and 'classic' Msbp, this model demonstrates that parents, at either end of the spectrum, share the common factor of being unable to differentiate their own needs from their child's, both in relation to seeking health care and consultations. They suggest that this type of formulation allows for comparing Msbp perpetrators with different groups of parents, not only those who cause harm, by neglect of their child's medical needs, but those on the edges of harmful fabrications. This latter group might be drawing attention and concern through abnormal illness behaviour in respect of their children while not actively fabricating.

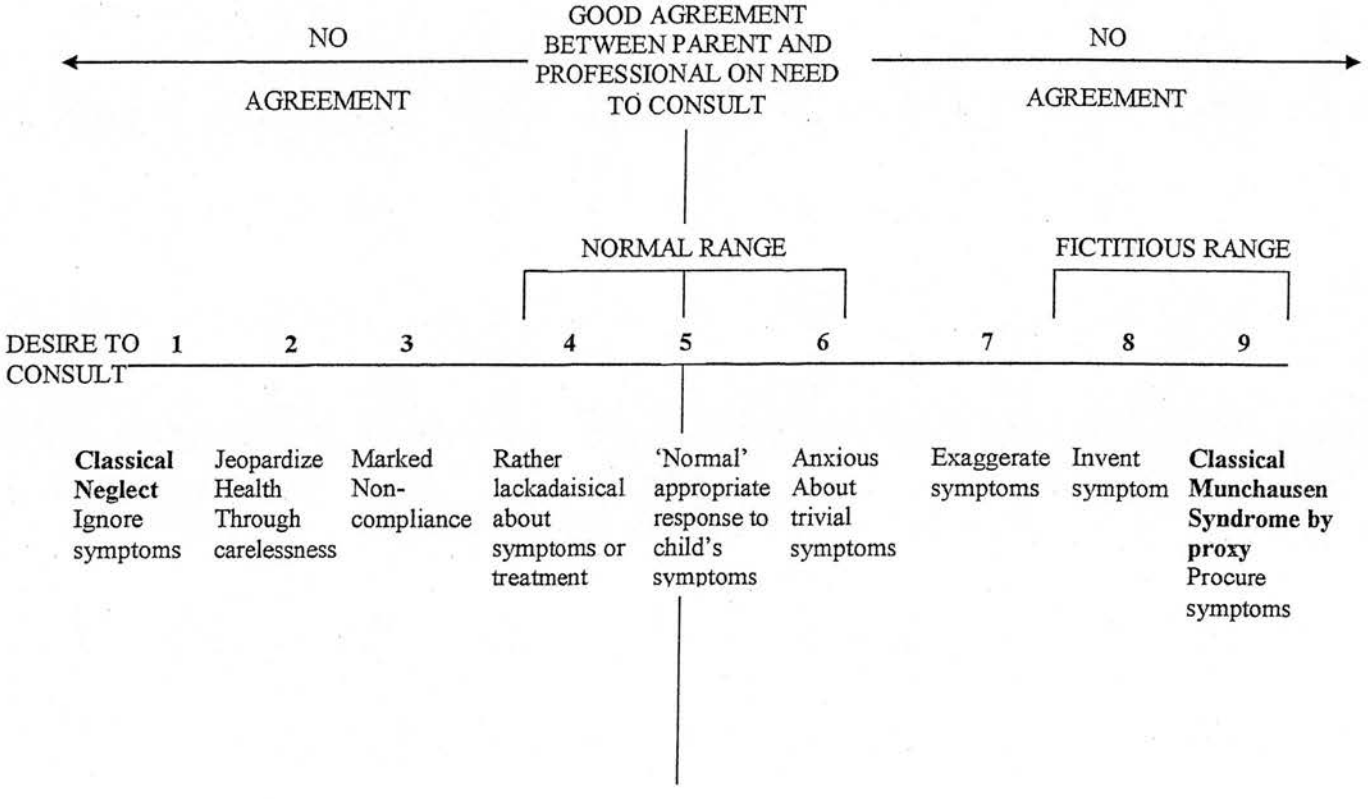

Figure 1 Parents' desire to consult for their child's symptoms (Reproduced From: Eminson and Postlethwaite (2000)

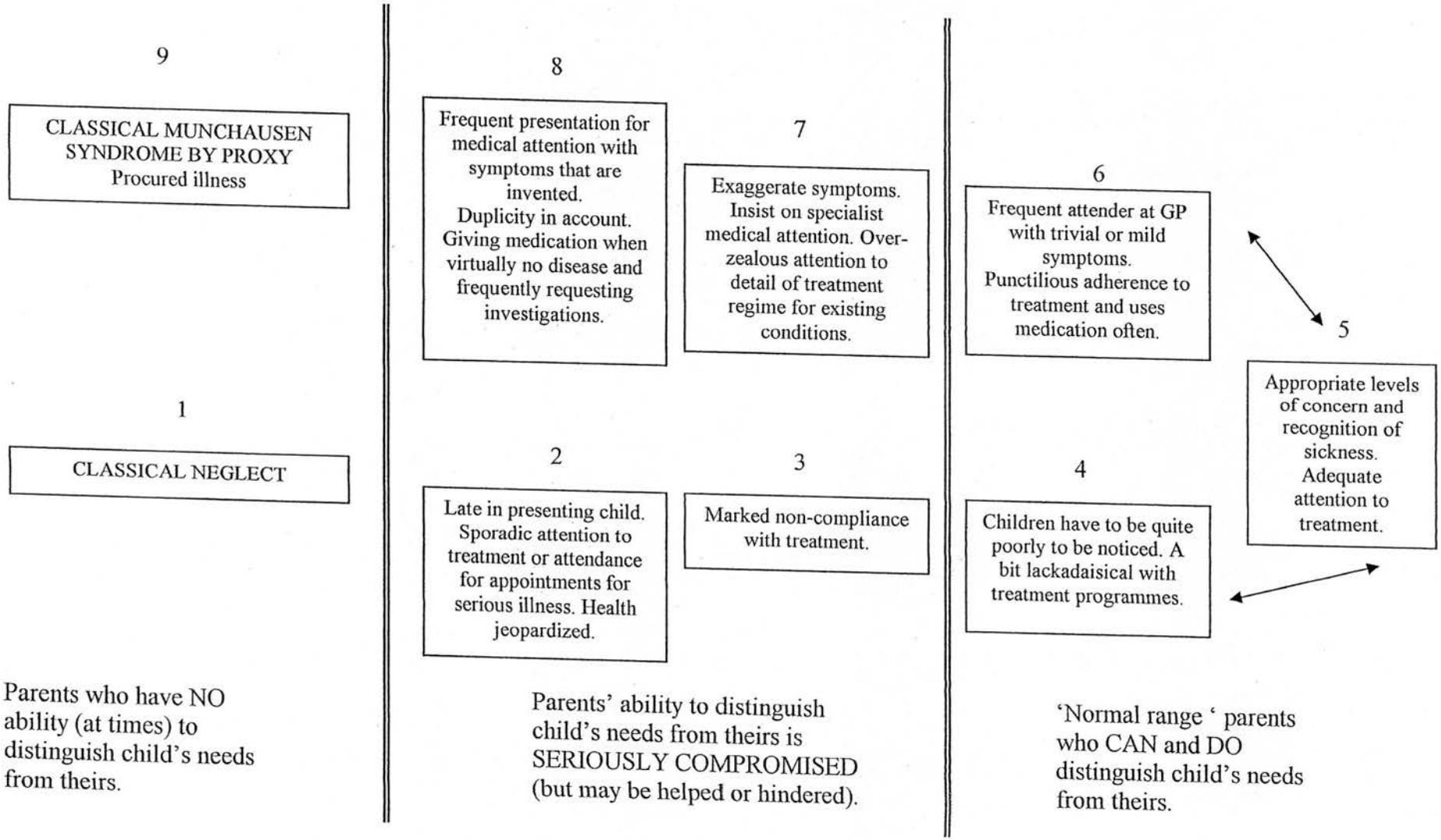

Figure 2 The spectrum of health care seeking by parents for their children.
(Reproduced From: Eminson and Postlethwaite 2000)

Summary

This section has set out the main themes and central approaches to the definition of Msbp. It is argued here that models, which offer a developmental ecological approach offer the best likelihood for understanding the origins of Msbp *behaviour* as well as informing child protection work and strategies for intervention. This is not to say that the pursuit of an understanding of motivation is not important but recognises its lack of usefulness in defining a form of child abuse. Schreier (2002) continues in the view that although motivation '*is difficult to know ..... it is not 'unknowable', being best left to people trained and interested in psychology'* (p543). This is a partisan view, unlikely to provide progress in understanding in Schreiers (2002) own words:

> *'the use of a sick child as a vehicle to maintain and regulate a relationship with Doctor(s) ..... and later with people seen as powerful.' (p543)*

This represents a strongly held psychoanalytical perspective.

Schreier alone (1996, 1997, 2000, 2002) and in collaboration with colleagues (1993) and as a contributor to an important set of papers (APSAC Task Force on Munchausen by Proxy Definitions Working Party 2002) has demonstrated the type, spectrum and width of harm represented in the terminology Msbp (the preferred terminology, here). Meadow's perspective has likewise been to emphasise the dangers which abnormal illness behaviour in parents for themselves represents to children (1995, 1996, 2002). And while this might logically seem the case, the comparatively few cases of Msbp do not permit such conclusions to be made. The lack of co-variant analysis with other populations of 'abusers' and manifestations remains an important area for research. This has been argued above and represents most of the thrust of Mart's (2002) objections to the conceptualisation and formulation of Msbp.

Children are potentially exposed to a spectrum of harm (Eminson and Postlethwaite 2000). Parents are likely to present on any hypothetical spectrum at any point, differently, across the life-span of the child and perhaps concurrently, as demonstrated in Eminson and Postlethwaite's model (1992). The neglect of a child's medical needs or the with-holding of treatment, whether to precipitate medical attention as in Msbp, or not as in classical neglect scenarios, provides an outcome of harm to a child, however arrived at.

The overlap with other serious forms of harm to a child contributes to definitional issues and provides evidence of there not being a discreet group of perpetrators with a particular motivational component. This has also stimulated debate as to the parameters of Msbp abuse. (Southall et al 1997). The work of Southall et al (1997) and Donald and Jureidini (1996) has indicated that mothers, who attempt suffocation of children both in and out of hospital settings have more in common with those who physically abuse children than those perpetrating Msbp through medically induced harm. This has led some to consider that suffocation not be classified as Msbp (Donald and Jureidini 1996).

The work of Feldman and Brown (2002) has contributed evidence that induced apnoea is less common, as an example of Msbp, in developing countries where use of baby monitors is less available, indicating hat there may be an opportunistic element to Msbp in hospital settings. To this extent it might be argued that hospital induced apnoea is iatrogenic in nature.

A change in emphasis removed from the debate about motivation which preoccupied the professional literature in the 1990s is now apparent. Eminson and Jureidini (2003) have suggested that time and energy would be better spent on research looking specifically at finding ways of enhancing treatment through the better understanding of somatisation and problematic areas in modern paediatric practice.

They are of the opinion that:

> *'Msbp abuse is the wrong kind of event to think of in terms of categorical diagnosis: rare events are inherently difficult to predict, and better research targets are available' (2003 lines 5-6).*

The diagnostic criteria advanced by Rosenberg (2003) exclude issues pertaining to the *inference of intent*. Her work now offers ways of identifying Msbp (albeit limited to hospital settings) which are evidence-based rather than relying on inference about maternal psychological functioning.

Chapter 3
Further Considerations
Women and Child Abuse

A 'flamboyant term', used once for 'journalistic' purposes (Meadow 1995) is, as a result, inextricably linked through the psychiatric literature with abnormal illness behaviour in adults (reviewed above) and the recognition of perverse parental behaviour in medical settings and the production of physical harm to children through their contact with medical professionals. This has come to be defined within the parameters of maternal need '*to assume the sick role by proxy*,' (DSM IV T-R 2000). This configuration has arisen from the merging of the paediatric and psychiatric research and theoretical literature, and emphasises explanations embedded in theories of individual psychopathology/mental illness.

The initial case notifications, immediately post Meadows 1977 paper, catalogued the various methods by which children can be harmed and only superficially addressed - if at all - the dynamics of the abuse. Subsequent large scale *epidemiological* research, most notably that of Rosenberg (1997) and systematic case-series (Meadow 1982 Bools et al 1992, Gray and Bentovim 1996 and Southall et al 1997) have provided information about the processes involved and have attempted to isolate key components of maternal psychological functioning. Evidence of abnormal illness in perpetrator-mothers in themselves has contributed to the further medicalisation of maternal behaviour without, it has been argued, the characteristics of a disease to substantiate this (Eminson and Postlethwaite 2000). This makes it difficult to extricate Msbp from a disease model. Historically, this preoccupation has detracted from the implications and meaning of the abuse to child-victims. This is widely recognised (Morley1995, Meadow 2002).

As argued throughout, theoretical frameworks, which evolved throughout the 19th and 20th centuries and developed for understanding organic physical symptoms (illness) are unsuitable for describing and understanding psychological experience and behaviour. This preoccupied the Anti-Psychiatry movement of the 1960s and 70s and has re-surfaced in the current debate in the psychological literature. Professor Boyle (2007), writing about '*The Problem With Diagnosis*', makes the point that statistical studies of unselected populations have indicated that people's actual behaviour and emotions *do not* easily fit diagnostic categories. She therefore makes the point that more valuable routes examining the reciprocal relationship between '*brain behaviour and environment*', which might identify strategies (and potentially policies) for prevention, are restricted.

Boyle's (2007) very radical suggestion of abandoning '*diagnosis*' and its categorisation systems has correctly (and intentionally) stimulated debate and prompted criticism (Langdon: Letter to The Psychologist 2007) as well as agreement. Johnson (Letter to The Psychologist 2007) has commented that since there is no evidence *for 'primarily biological causal mechanisms that would justify describing psychiatric conditions as disease processes'* (p412) that other ways of formulating behaviour are required, which are personally meaningful to the individual rather than abstract concepts. This permits a shift from '*patients with illnesses to people with problems*'. This embraces the possibilities inherent in systemic interactional approaches to understanding parents and ultimately to understanding and preventing child abuse.

Nowhere in the literature are explanations available to account for why a child is used as the *by proxy* form of adult abnormal illness behaviour. It begs the question why anyone, particularly a parent would wish *to assume the sick role* through a child as opposed to *adopting the sick role.* Glamorised media images of Doctors and medical practice have been cited as influential (Schreier 1993). Meadow's (1977) own early recognition of the psychological benefits to be had from being in a secure

paediatric setting was near the mark. Later writers will provide fuller analyses of what is broadly referred to as the *iatrogenic* nature of Msbp abuse, in texts, whose emphases are practice based rather than theoretical (Eminson and Postlethwaite (2000), and Parnell and Day (1998), Artingsall (1995).

The severity of Msbp abuse of children in terms of physical and psychological harm drives the inevitable assumption that *there must be something wrong* with mothers, who bring about harm to their own children through illness falsification, in whatever form that takes, in spite of there being no single characteristic yet found, which is likely to provide '*the litmus test*' (Eminson and Postlethwaite 2000) for identifying Msbp perpetrators. Rosenberg (2003) has recently commented that while '*some sort of state of mind must underpin the conduct, not every case will equate with psychiatric disorder'. (P427).*

Motz (2001) supports a more comprehensive understanding of motivation and wider recognition of the harm that children experience at the hands of their mothers. Her perspective on female violence both self-inflicted and towards children points to the importance of working within models of female functioning, which emphasise the link between aggression and victimisation: models, which make explicit how damaged and depressed women can move from victim to victimiser, thereby posing a risk to children (p87).

Motz (2001) argues that the denial - or lack of acceptance of female violence - stemming from what she describes as '*professional blind-spots*' derived from the cultural idealisation of women and motherhood, is evident in the acceptance of psychological disturbance in women as offering explanations for child abuse, their culpability and aggression over-looked. This likewise creates systemic disbelief and often conflicts between professionals. While Motz (2001) perhaps over-states her case in one respect at least: Meadow (2002) has consistently drawn attention to the dangerousness of Mothers, whose abnormal illness behaviour in themselves is

subsequently made manifest by extension (by proxy) in their child - her opinion that women's disturbed (or, disturbing) behaviour has historically been located within models of psychopathology and mental illness has been argued here and elsewhere. This view is endorsed by Falkov's (1996) review of fatal child abuse, from which the significance of '*somatising behaviour*' in parents, who go on to kill children emerged.

Allison and Roberts (1998) and, most notably Showalter (1985) in her book '*The Female Malady*', have advanced the theory that '*cultural ideas*' (stereotypes) of female behaviour have shaped the definition and treatment of female patients. Although Showalter has been criticised as merely replicating what Busfield (1996) describes as '*feminist orthodoxy*' in the absence of empirical data, her view is not without foundation. The compulsory incarceration and resultant institutionalisation of women, who *fell* pregnant out of wedlock, exists within living memory.

Busfield (1996) has argued that the reluctance and failure to accept and, therefore, recognise the potential in women to harm children has influenced and directed a subtle process of '*re-framing*', which locates women with the locus of *madness* and outwith delinquency and aggression. This leads to notions of treatment models and, as argued here and throughout, equates with models of maternal psychopathology. Busfield (1996) and Motz (2001) are concerned about the loss of focus on the abuse of the child. Motz (2001) argues that the terminology of Msbp provides no indication as to exactly what has happened to the child physically or, psychologically. Busfield (1996) likewise has suggested that using the terms *Msbp abuse* permits focus to be placed on the child, whereas Msbp per se simply '*identifies parents as patients*'.

Perspectives on female (sic maternal) violence embedded in theories of mother-child attachment hold out hope of a better understanding of the pathways to Msbp abuse Motz (2001). The wider child abuse literature, not specific to Msbp, appropriately

draws attention to issues in wider family functioning (Reder and Duncan 1999) and mechanisms of inter-generational transmission of difficulties, particularly in attachment (Motz 2001). This does not detract from the mother as pivotal but provides definitions of behaviour, which are not wholly accounted for by psychopathology and psychiatric illness, and which incorporate issues pertaining to the contexts in which abuse has occurred.

Drawing considerably from Attachment Theory (Bowlby 1969, 1973, 1980. Ainsworth 1985), which offers intra-psychical explanations of mother-child attachment and the effects on child development of the reciprocal interactions between mother and child, crucially in the early stages of life, Motz (2001) has argued that Msbp represents a *failure of differentiation* between one's own needs and those of a dependent child whose right it is to develop a separate identity. Psychodynamic theory describes this as *narcissistic*, the child's body becoming (or remaining) an extension of the mother's (Welldon 1991, 1996). This offers metaphorical parallels to self-harm, in which psychic conflicts are played out in physical terms (Motz 2001). This also accords with psychodynamic theories of *transference*, described above and below (Schreier 1993).

Problematic attachment irrespective of the theoretical perspective may form a family pattern providing inter-generational transmission of difficulties in preventing inadequate or inept levels of parenting. Avoiding the controversial issue of female v male carers - consistency being more important to child development, in particular psychological adjustment - poor attachment between child and 'carer' carries a high tariff for later adverse outcomes, potentially in all areas; cognitively, behaviourally and psychologically.

Attachment theory will not be further elaborated here, being a vast and significant area in child development, on its own, except to note that although theoretically embedded in Freudian psychodynamic explanations of infant development, its

observations about mother-child interaction (in particular, reciprocity) have been embraced by other theoretical perspectives.

Jones et al (2000) have likewise made the link between problematic attachment and Msbp with later psycho-social difficulties evidenced by self harming behaviours, depression and substance/alcohol abuse.

There is value in integrating information from other areas of the literature on child abuse. Such an approach recognises that abuse is more likely to have its roots in risk factors within and also beyond individuals, and within wider contexts, such as the family. The inter-generational aspect of child abuse *seen* as a *process*, rather than *a series* of separate acts, is emphasised. This approach recognises what Falkov (1997) has referred to as a '*web of influences*', in which psychopathology is only one component. Viewed from the child's respective, Ron Britton's description of them as '*actors in someone else's play*' (quoted in Reder and Duncan 1999) is particularly apposite – for whatelse is Msbp if not a series of scripts and narratives pertaining to illness.

The work of Reder and Duncan (1999) in the area of fatal child abuse has examined antecedent and prerequisite events prior to the death of a child, in relational interactional terms. They point to the need to understand the timing and contexts, in which fatal child abuse occurs. They have identified what they describe as '*abusive circumstances*' on which they have based a model of risk. Key markers relate to: the parents' own experience of poor parenting and their unresolved issues relating to this, a vulnerable child from the point of view of the '*meaning*' of that child to its parents, at a particular stage, and a constellation of life stressors.

A number of other factors have been cited as significant in child abuse: alcohol/substance abuse with associated life-styles (Kelley 1992, Famularo et al 1992); depression (Falkov 1996, Wilczynski 1995, 1997); within child factors e.g

illness, fractious behaviour (Greenland 1987). Poverty and fractured families are consistently found to be widely associated with abuse (Brown and Saqi 1988, Whipple and Webster-Stratton 1991).

As a general comment, the child abuse literature can be ambivalent as to the rank-ordering and significance of risk factors. By way of example Falkov's (1996) study of Part 8 Reports (child deaths) showed clear evidence of psychiatric morbidity in 32% of the case histories available to him. In a similar study of neonaticide Wilczynski (1997) uncovered no evidence of psychiatric disturbance, a finding corroborated elsewhere (Burnett 1993, Fitzpatrick 1995). These findings, indicating that the age of the child is significant bears comparison with Reder and Duncan's (1999) concept of '*the meaning*' of the child in the family at a given time in life cycle transitions. The child is one aspect of a larger set of dynamics. Reder and Duncan (1999) sum this up:

> *'it was as though the children acquired an undeclared script or blue-print for their life that submerged their personal identity and characteristics and this meaning came to dominate the parent-child relationship'. (p71)*

There is current agreement that Msbp is likely to reflect intra-psychical and intra-familial conflicts (Parnell and Day 1998) giving rise to attachment and parenting difficulties between mother and child. The evidence that even quite young children will appear to collude with their mothers by simulating illness (Croft and Jervis 1989) and evidence of induced factitious psychogenic symptoms (Schreier and Libow 1993, Parnell and Day 1998) points to likely disfunction in parenting in line with failures in differentiation and separation as described by Motz (2001). The need for full family assessment in order to understand the meaning of abnormal illness behaviour to the mother, within the family, and how parent-child interactions contribute to the child being brought to the stage of colluding or actively simulating illness, in themselves, emerges as crucial, particularly in the later processes of decision-making as to the rehabilitation of the child to the family.

Evidence from Children who Collude

Early reported cases involving child collusion have tended to be treated as cases of Munchausen Syndrome, which might be questionable. To borrow Summit's (1981) terminology, it is more likely the case that the children have *accommodated* to their mothers creation of them as being ill. Also, the benefits in terms of being kept away from school are obvious. However, in extreme cases, in which children begin to collude to the point of self harming/fabricating, independently of their mother's involvement, the consequences might be medically very serious. Collusion is likely to render detection even more complex.

Croft and Jervis (1989) describe the case of a four year old boy, who feigned epileptic fits having been coached by his mother to fall to the ground shaking and to feign unconsciousness. This behaviour persisted in her absence.

Schreier and Libow (1993) describe the case of Danny, who had a history of self-harm and reported allergies. After a visit to a local park he was taken to hospital by his mother in moderate respiratory distress. In response to his mother repeating 'you can't breathe' Danny went into respiratory arrest and subsequently suffered permanent brain damage. Likewise, Parnell and Day (1998) describe the case of Tammy, who, by the age of six had over 40 hospitalisations and was subjected to numerous medical procedures. Tammy is cited as a case of psycho-genic vomiting, since she could vomit, at will, particularly in her mother's presence and improved in her absence.

The early cases of Munchausen Syndrome *per se*, in children, might not stand up to scrutiny in the light of current understanding. Tec's (1975) reporting of what he believed to be the first case of Munchausen Syndrome, in children, is probably misdiagnosis. He described the case of 10½ year old Danny, who presented with a range of physical pain and emotional disturbance (anorexia nervosa)

contemporaneous to his father's demands that he become a football player. His symptoms disappeared following a holiday and being subsequently sent to a boarding school away from his father's demands (cited in Parnell and Day 1998 p31-32). A more likely interpretation of Danny's case is that of stress due to his inability or unwillingness to fulfil his father's expectations. The search for explanations of his '*eating disorder*' might better be cited within wider family functioning rather than within child psychopathology.

The hand of a parent cannot be ruled out and eliminated in the case of a 10 year old boy presenting pebbles as factitiously passed renal stones (Sneed and Bell 1976). Similarly, the sophistication of a 13 year old's simulation of a cerebral spinal leak, by putting beetroot juice in his ear, merits hesitation in describing this as a case of MS (Gilbert et al 1987) if only for its medical sophistication and the level of knowledge required. It might also be argued that Parnell and Day's (1998) case of psycho-genic vomiting (Tammy) was a severe stress reaction to her mother.

The importance of these cases lies not so much in their content as in the direction they point. As already noted, they provide evidence that there is a need to understand the meaning, which illness has not only between a parent and child but within families. This becomes particularly difficult to tease-out in cases, in which there is a pre-existing medical condition, in '*mixed-cases*' or where there is a natural tendency to exaggerate illness and symptoms. Collusion complicates the picture further. Evidence of direct tampering and contamination will often only provide the most robust physical evidence.

How children come to collude with these processes has been described by Sanders (1995), who has advanced a continuum of child response from lack of awareness of symptom production to cooperation and on to active harm in themselves. Sanders (1995) argues that the maintenance of the relationship with the mother is central to collusion, the child comes to effectively know no other life, which is perhaps one of

the most distressing aspects of Msbp abuse. Throughout the literature is noted (Libow 1995) the obvious and long-term morbidity for children effectively self-harming in this way. The most perplexing aspect about collusion is its capacity to obstruct intervention by all professionals, but most particularly by child protection agencies, in the absence of robust incontrovertible evidence of the mother's actions, to a legal standard of proof.

Msbp: A Paediatric or Psychiatric Conclusion?

There is general agreement that Msbp is a Paediatric conclusion based on medical evidence and is not one arrived at on the basis of theoretical or observational information about mothers and their states of mind in hospital settings but derived from robust evidence as to the harm to the child (Rosenberg 2003). Equally, dangers inherent in misinterpreting parental behaviour and presentations under stress have been identified (Morley 1995) and are not probative of child abuse.

Rosenberg's (2003) recent work shares the view that there is no unifying psychopathology, which affects all perpetrators of Msbp (Morley 1995, Eminson and Postlethwaite 2000), Rosenberg (2003) argues that no assumption should be made about maternal state of mind prior to assessment: equally the state of mind, which underpins Msbp need not be synonymous with a psychiatric disorder. Dealing as a whole with what are central issues in respect of different levels of diagnostic certainty in Msbp cases, Rosenberg (2003) emphasises the distinction between the '*definition*' of Msbp and its diagnostic criteria, which permits it to be differentiated from other diagnoses . She notes that diagnostic criteria must be *present*, *pivotal* and *observable* and it is against those elements that a hypothesis can be generated as to the nature of a child's presentation. Msbp becomes part of the differential diagnosis. She argues that the definitive diagnosis of Msbp is *the clear* diagnosis (physical evidence) arrived at by inclusion or by exclusion which permits it to be differentiated from other diagnoses. The latter consists of incontrovertible

evidence of commission whereas a diagnosis of exclusion is arrived at when it is *the only one left standing after exhaustive investigation.*

Rosenberg (1995, 2003) advances inclusion and exclusion criteria against which medical evidence in terms of '*different degrees of diagnostic certainty*' can be evaluated as part of the process of building a diagnostic hypothesis. Recognising inherent difficulties in the use made of taxonomic systems akin to the professional literature on Msbp *(misquoted, misapplied, misapprehended and misconstrued P428)* her emphasis on establishing the burden of medical proof as opposed to the state of mind of the perpetrator is significant. Her observation that intent (motivation) cannot be a diagnostic criterion due to the fact that it is *inferred* and not *observable* takes arguments in definition beyond the realm of individual functioning, at least at the stage of establishing that abuse has taken place.

'This explains why Msbp is a paediatric, not a psychiatric diagnosis: only observable criteria can be used for diagnostic purposes. Munchausen Syndrome by Proxy is a collection of acts, not simply the predisposing state of mind. Indeed, the state of mind absent the facts, is not Msbp. Acts, or the forensic evidence of acts, are observable. States of mind are not. Rosenberg (2003 p423).

Referring to the paper, which emerged from the case of Kathy Bush (State of Florida v Bush 1999), Schreier (2002) has reiterated the importance of establishing motivation as providing a context for Msbp behaviour p547. Here, he revisits the theoretical stance of 'Hurting For Love' (1993) and its emphasis on dynamic motivations and takes Rosenberg (1995) to task in matters of understanding motivation. Schreier notes that where he agrees '*that motivation in Mbp is difficult to know*', he disagrees that motivation '*which by its very nature is circumstantially evidenced is unknowable*' (p543).

Citing Rosenberg's (1995) expert testimony in an earlier case (Kelly –Frye 1995) as being influential in swaying subsequent legal determinations to exclude factors in respect of *motivation,* as in the State of Florida v Bush (1999), Schreier (2002)

argues that as a result of these exclusions of arguments in respect of the motivation to abuse a child, juries are left to decide cases on circumstantial evidence alone (p538) whereas establishing a motive for the crime by providing Msbp evidence might make the evidence more persuasive. He quotes from the judgement on Reid v State 1998:

"Msbp evidence would be useful to assist the trier of fact in determining the motive for the defendant's acts [and is relevant because] ..... Although a prosecutor ordinarily need not prove motive as an element of a crime, the absence of an apparent motive may make proof of the essential elements of a crime less persuasive .... In light of other information which was before the jury concerning appellant's demeanour personality and character, including the fact that she was the mother of the child, without other relevant and reliable evidence, the conduct ascribed to the appellant was incongruous and apparently inexplicable. Msbp testimony would, if accepted by the jury, bridge that gap (538-539).

This is clearly a complex issue for all professionals concerned with Msbp cases, with the very obvious inherent pit-falls in establishing motivation as described by a range of writers (Mart 2002, Morley 1995) and using this in a legal context, which is perhaps why Paediatricians now congregate around a definition, which emphasises acts of child abuse, leaving issues in respect of motivation to psychologists and psychiatrists (Meadow 2002). (It is something of an irony that the man responsible for the confusion now willingly relinquishes the need to explain motivation, elsewhere).

Rosenberg's (1995, 2002) criteria that Msbp is a *paediatric* and not a *psychiatric* diagnosis makes clear where the burden of proof has to lie i.e. in medical evidence of abuse and makes clear issues in respect of professional responsibility (Morley 1995). This point she demonstrates in a factitious scenario involving induced suffocation in an infant, by its mother. If content (motivation) could not be proved then even in the face of incontrovertible evidence of covert video surveillance, professionals would be constrained from making the diagnosis if no agreement could be reached as to motivation, which she describes as a logical flaw.

This thesis agrees with Rosenberg's (2003) position in respect of there being no unified theory of maternal psychopathology but recognises Schreier's (2002) emphasis on the need to understand motivation if only because of the compulsive and dangerous nature of some forms of the abuse although his position on psychological transference is not. However, understanding *motivation* or the *state of mind* under pinning behaviour does not equate with psychiatric disorder or psychopathology (Rosenberg 2003). That this should be used to persuade juries of the true nature of perpetrators, who would otherwise appear '*incongruous*' is of concern and smacks of behaviour matched to diagnostic label not to mention trial by personality. Information about maternal psychological functioning (*always inferred*) is primarily useful in guiding therapy, in providing an assessment of risk to children and on decision making about future rehabilitation. Ironically, even then, little might be taken with surety about a group, whose behaviour is described as characteristically duplicitous. This is a recognised by Schreier (2002) and noted elsewhere (Mart 2002).

Problems Inherent In Diagnostic Models

The comparatively recent DSM-IV- text revision (American Psychiatric Association 2000) has done little to clarify understanding of Msbp. Factitious Disorder by Proxy (the DSM classification does not use the term Munchausen Syndrome by Proxy) is a term used for the perpetrator and not for the abuse itself or the child as victim. Meadow (2002) has recently attempted to verify the core aspect of Msbp as describing acts of child abuse. He himself highlighted the difference in focus between Paediatricians, whose primary interest is the child and psychiatrists, whose interests lie fundamentally in understanding behaviour and in diagnostic labelling. However, Meadow himself has consistently clung to a psychodynamic theme in his reiteration of '*to assume the sick role*' as the main motivating factor in Msbp. The

later concession in the shape of '*or another form of attention-seeking behaviour*' does not wholly detract from this.

The tension between diagnostic models and those, which could be described as their equivalent – sociological and psychological models of public health and environmental medicine or, as has been frequently referred to here – systemic models - is the subject of considerable current debate in the psychological literature. The '*anti-psychiatry*' theme of Laing (1964) and Szasz (1974), which was more benignly translated to '*Critical Psychiatry*' (Ingleby 1980), is echoed in the concerns of the Midlands Psychology Group (BPS 2007).

Joseph (2007), describing the real focus of psychology as being the promotion of mental health, rather than illness, argues (as did Maddux 2004) that the practice of psychology has become entrenched within an illness ideology based on the medical model. He calls for the rejection of the categorisation and pathologisation of human experience and the assumption that mental disorders exist in isolation of cultural influences.

Non-medical models have the potential to offer ecological perspectives on personal behaviour and distress and explanations of how, in some extreme cases, this can add up to the abuse of a child. They are likewise more congruent with interactional models of child abuse, which hold that a person's behaviour is best understood as a function of the social and relationship contexts of their lives (Reder and Duncan 1999).

Inherent difficulties in diagnostic models, in terms of providing a stable differentiation of '*normal*' from '*abnormal*' behaviour create problems in defining Msbp maternal behaviour, particularly in hospital settings. A number of writers

have addressed what has become a core difficulty in differentiating between mothers, whose behaviour may be problematic but non abusing (Eminson and Postlethwaite 2000, Mart 2002). Different theoretical models have been advanced, which offer the potential to distract from issues of individual psychopathology although facing some of the same criticism of subjectivity.

Finally, the definitional conundrum, which Msbp presents has been well described by Baldwin (1996), who outlines what is an apparent contradiction of Msbp. Its emphasis on individual psychopathology, fits well into disease models of child abuse: conversely, it can only really be understood in relational terms in what Baldwin refers to as *'clinical and social'* iatrogenisis, by which he means the medicalisation of society and childhood itself. This might presumably also be understood in terms of systemic processes engendering and sustaining abuse as well as interpersonal relationships with Doctors in health care settings. This theme is picked up by most major contributors to the literature. Feldman and Brown's (2002) work examining cross-cultural demographics and features of Msbp abuse in developing medical systems abroad, taps the same seam. Their work provides some justification for interactional as opposed to (individual) psychopathological explanations of child abuse.

It has been useful to outline these professional-theoretical concerns by way of an introduction, prefacing the central themes of this section in respect of the clinical validity of Msbp, medical labelling and, crucially, the definition of a form of child abuse by motivation, defined within a particular context.

CHAPTER 4

Munchausen Syndrome by Proxy: Epidemiology, Mechanisms and Spectrums of Harm

EPIDEMIOLOGY

This section will examine the epidemiological evidence for Msbp and will describe the mechanisms and spectrum of harm. It shares the characteristics of other forms of child abuse in that the incidence rate is inherently difficult to determine. This is compounded by, primarily, a lack of recognition but also definitional issues contributing to a lack of confidence in reaching the conclusion of Msbp with subsequent under-reporting. Many *other* factors may contribute to this: professional reluctance to admit being deceived (Sheridan 1994) and the length of time required to reach a diagnostic conclusion in more complex cases. This can be variable with a range of 6m to 14.9 years (Schreier and Libow 1993, Rosenberg 1987). In the severest cases of Msbp, children die: some of these deaths will be recorded as SIDS. The confidential Enquiry into Sudden Death in Infancy (CESDI SUDI Studies (1993-1996, 2000) was hampered in its collection of data from the office of National Statistics (ONS) by the complications provided by inconsistent use of definitions and terminology as well as the use of different classifications to code infant deaths. The Cesdi study anticipated similar inconsistencies worldwide, rendering data and comparison studies, unreliable.

The RCPCH Guidance (2002) on F.I.I. by carers draws attention to problems in the meta-analysis of case-series; in particular, the subjective (often uncorroborated) diagnosis in the first reported cases, historical problems specific to terminology and methodological problems accruing to the ascertainment of cases. There can also be problems inherent in the retrospective recall of cases, either by professionals or victims in psychoanalysis in later life (Libow 1995).

Rosenberg: Web of Deceit (1987)

This study provided the first bench-mark epidemiological information for Msbp, drawn from a meta-analysis of 117 cases, obtained from a literature review. Although widely cited in the literature, problems inherent in meta-analytical approaches have been raised, which cast doubt on the validity of the data (Allison and Roberts 1998, Meadow 2000). Methodological issues have likewise been raised (Allison and Roberts 1998) in respect of a fundamental sampling error in the calculation of cases, matching Rosenberg's (1987) own syndrome cluster.

Meadow (2002) has also drawn attention to Rosenberg's (1987) '*syndrome cluster*' for Msbp (described above) as being too inclusive. Although Rosenberg (1987) excluded cases of physical, sexual and non-organic failure to thrive occurring alone, Meadow suggests that '*the cluster*' did not exclude cases, which overlapped other forms of '*Doctor-shopping*' or parental abnormal illness behaviour causing harm to children. Their lack of specificity is raised by Allison and Roberts (1998), who suggest that Rosenberg's (1987) attempt to cover a broad range of disparate signs and symptoms (p146) undermines the definition. They likewise point out that the definition overlaps the symptom characteristics of other disorders and, indeed, forms of child abuse.

Rosenberg's selection of cases, based on their conformity to her definition in the syndrome cluster, predetermined what would be included in the study. At a more fundamental level, Allison and Roberts (1998) have noted that of the 117 pre-selected cases identified by Rosenberg (1987) from her personal review of the literature, 45 of these failed to yield information about the simulation and/or production of illness (Criterion I) by a mother in a child. These by definition, *unusable cases*, continued to be factored in so that the total sample size of 117

remains and is, for the purpose of later calculations, quoted throughout the paper by Rosenberg.

In view of this, Rosenberg's (1987) figures for short-term and, particularly long-term morbidity (8% of victims) and mortality rates (9% of victims) require adjustment. Allison and Roberts (1998) have also noted that there is no evidence cited by Rosenberg (1987), which could have pointed her to the conclusion that the deaths of 10 children related to Mbps. Eight of the 10 dead children were under 3. Establishing the cause of death in the absence of an organic cause is difficult but is particularly problematic when arriving at the conclusion from case reviews. Other causes might have contributed to their deaths or in the absence of any evidence of such, SIDS (SUDI) should have been the conclusion, as opposed to Msbp.

Most of the cases of Msbp have been reported in Britain and America and predominantly by Paediatricians (Schreier 2002). Cases noted in international journals indicate that it is a worldwide problem (Parnell and Day 1998). The work of Feldman and Brown (2002) described above, has extended understanding of how opportunities to harm children, through illness falsification or fabrication, have become more available to mothers in developing countries, where adopting western style approaches to diagnosing illness, through the use of medical technology and biomedical testing, has partially supplanted first-line history taking and clinical assessment. Feldman and Brown's (2002) work has cast some light, if indirectly, on scenarios, in which children are indirectly harmed through medical intervention, in British hospitals.

Early attempts to establish epidemiological data for Msbp were carried out initially within diagnostic groups of children. Godding and Kruth (1991 in Parnell and Day (1998) identified 1% (17 of 1,648) children attending an Asthma clinic as Msbp. Light and Sheridan (1990) in Parnell and Day (1998) has suggested that 1% of infants on apnea monitors might be victims. An early paper by Warner (1984)

identified 5% (16 of 301) of children attending an allergy clinic as victims of fabrication (in Parnell and Day 1998).

Polls of paediatric specialists most likely to be involved in cases (neurologists, gastro-enterologists) have been employed (Schreier and Libow 1993) but do not yield valid estimates of the incidence or prevalence of Msbp since they do not tap the spectrum of harm and manifestations of Msbp, which might not be referred to sub-specialisms.

The first systematic epidemiological research in Britain, was carried out by McClure, Davis, Meadow and Sibert (1996), described in detail, below.

The British Paediatric Association Surveillance Unit (BPSU) Study 1992-94.

This two year prospective study (1992-94) was carried out in the UK and Republic of Ireland to determine the epidemiology of Msbp, non-accidental poisoning and non-accidental suffocation, and whether they were related or overlapped. Rogers et al (1976) first drew attention to non-accidental poisoning in children, which they described as '*an extended form of child abuse*'. Rosen et al (1983), Stephenson (1990), Meadow (1999) and Southall et al (1997) provided the first case series of suffocation and asphyxiation of children, by their mothers.

Ascertainment of cases was through the British Paediatric Association Surveillance Unit (hereafter BPSU) and the system of monthly report cards. Consultant Paediatricians were asked to provide confidential nominations and subsequently information about cases of Msbp and of non-accidental poisoning and non-accidental suffocation, which they had encountered, in the previous month. The entry criterion was the convening of a Child Protection Case Conference (hereafter CPCC). The information was scrutinised and analysed statistically.

Responses provided 210 cases of which 82 were excluded as not matching the inclusion criterion or failing on other counts. The criteria were reached by 128 cases, of which 97 were considered to be Msbp. Thirteen of the children were on the child protection register.

The incidence level of Msbp, non-accidental poisoning and non-accidental suffocation was 0.5/100,000 children under 16 years. 70% of the cases noted were in respect of children aged below 5 years. The peak annual incidence was in children under 1 year at 2.8/100,000 children. This indicates that it is easier to fabricate or induce illness in pre-verbal children. Msbp occurred in isolation in 55 cases and 15 cases of non-accidental poisoning and 15 cases of non-accidental suffocation occurred in isolation, not associated with fabrications to Doctors. False history alone was provided in 23 of the 97 Msbp cases. In 21 cases the adult fabricated symptoms as well as providing a false history. Actual harm was inflicted on 53 children by adults, who also provided falsified histories and fabricated symptoms.

Forty four children were poisoned. Thirty-eight different poisons were used (71% used prescribed drugs) most commonly anti-convulsants and opiates. Thirty two children were suffocated. Forty-three children experienced two or more forms of abuse. Only one child in isolation was subjected to poisoning and suffocation not associated with Msbp.

Ninety-two cases presented as emergency medical problems to the Paediatricians, who notified the cases and 31 (24%) presented as non-acute out-patients. Five children were medically assessed following child protection procedures.

The BPSU Study provided the first evidence of the overlap between Msbp, non-accidental poisoning and non-accidental suffocation and the conclusion that

poisoning and suffocation are unlikely to occur as manifestations of child abuse *in isolation* and were, therefore, strongly linked with Msbp.

The work of Southall et al (1997) has provided further evidence that children might experience a range of different types of abuse. Their investigation of cases referred for the investigation of apparent life-threatening events (ALTE) using covert video surveillance (CVS) showed intentional suffocation occurring with other deliberate forms of physical harm: poisoning with disinfectant and anti-convulsants, fractures as well as emotional abuse.

Child Characteristics

Age

The most vulnerable children appeared in the younger age groups giving a median age at diagnosis of 20 months. As noted above, pre-verbal children are the more vulnerable by dint of not being able to tell what is happening to them and by being totally available to the mother for victimisation through abuse. Thirty children were over 5 years and, of this group, 19 experienced Msbp alone leading to speculation that there might have been collusion in the older children.

This interpretation is substantiated elsewhere in Libow's (1995, 2002) work on the intergenerational nature of Msbp, in families, and by the work of Sanders (1995), which has provided evidence of symptom *coaching* in older children. Children may also come to believe their mothers that they are ill or collude to preserve the relationship. In some cases, older children have been shown to validate the mother's story and to go on to fabricate in themselves (Schreier and Libow 1993, Libow 2002).

Eleven of the children over 5 were poisoned. Five of this group had learning difficulties and 6 were unaware that they had been poisoned. No cases of non-accidental suffocation were reported in this age group.

Perpetrator Characteristics

In the BPSU Study, the mother was the sole perpetrator in 109 cases (85%). In the 97 cases of Msbp, the mother was the sole perpetrator in 94 and suspected in two others. This is markedly different from other forms of child abuse, where perpetrators are predominantly male (Reder and Duncan 1999). Two cases involved a father alone and in two others, a grand father and boy-friend were suspected. In only 8 cases was the mother *not* suspected as involved.

Morbidity and Mortality

The psychological consequences of Msbp are difficult to quantify or evaluate. There may be further elements in the child's experience of the family, which would render it nigh impossible to tease out particular psychological outcomes, as being attributable to Msbp abuse alone. Many children reared in abusive families, who have experienced physical harm, may be expected to have also a range of experiences, which constitute risk factors for later development, and their own psychological functioning, which in consequence predict poor outcomes in later life, in terms of social functioning, emotional stability, esteem and self-competency.

The work of Ney, Fung and Wickett (1994) which has examined the long-term effects of combinations of abuse and neglect in childhood suggest that the most severe psychological difficulties come from *neglect*, which they suggest is often a precursor to other forms of child abuse. They likewise conclude that when the onset of neglect precedes abuse, compared to when the onset of abuse occurs at the same

time or precedes neglect, the mean effect of the neglect was significantly greater. Neglect can take many forms, physical and emotional: the latter is associated with problematic disrupted development associated with poor maternal/child bonding and interaction.

Ney et al (1994) suggest that the vulnerability of a child is to a great extent determined by the coincidence of other transition events in the family and sources of stress or what they refer to as '*an interlocking web of influences contributing to child maltreatments*' (1994 p55).

The most considered interpretation of child abuse sets it within the context of wider family functioning and processes across the life spans of its members. This is embedded in the work of Reder and Duncan (1999). If Msbp is attributable to problematic attachment, Jones (2000) or '*a severely dysfunctional relationship between parent and child*' Southall et al (1997 p739), then these processes may, for some children, at least, have begun from birth or potentially earlier. The fabrication of gynaecological symptoms and obstetric problems (premature rupture of membranes, artefactual fluids in sanitary towels) is noted in the RCPCH Guidance (2002) and in the work of Jureidini (1993).

Msbp is considered so insidious in its effects that Rosenberg (1987) unreservedly put childhood morbidity at 100%. In a study of 54 child victims of Msbp, 23, who were left with their mothers, experienced further abuse, 10 cases of which were Msbp. The children, who were removed, experienced no further abuse: however a range of emotional and behavioural difficulties were noted in both groups (Bools et al 1992). This study did suggest, however, that those children, who had been placed in good foster care *prior* to being returned to their biological mother, fared slightly better on outcome measures than those who remained with their mothers. Bools et al (1992) concluded that the long-term morbidity of victims of fabricated illness was substantial.

Of the cases notified to the BPSU Study, 8 died as a direct result of their abuse from either poisoning or suffocation. Fifteen children required intensive care and a further 45 were judged by Paediatricians to have suffered physical illness and 31 minor illness.

One hundred and twenty two children were admitted to hospital as a result of their abuse and 119 were subjected to inappropriate invasive investigations or treatments, including drugs. Only 8 children of the 122 children reviewed were not subjected to investigations or treatments.

Sibling Deaths

Of the 128 index children notified, 83 had at least one sibling. Fifteen of these had a dead sibling (18 children), 5 of which were categorised as sudden infant death syndrome (SIDS). Thirty four of these families were known to have had a further sibling who had experienced abuse: Msbp (17) suffocation (5), poisoning (5), physical abuse (5), neglect (5). In 7 of the 34 families a further 8 children had died. One died from suffocation and physical abuse and two were categorised as SIDS and 4 were of unknown cause. This provided evidence that more than one child can be victimised in a family and that abuse can take many forms.

The RCPCH Guidance (2002) recognises that families can have recurrent child deaths due to natural causes and that some clinical categories of FII are associated with an increase in child deaths of siblings, some of which were previously categorised as SIDS. In a study of 39 children referred to two hospitals (London and N.Staffordshire) for investigation of A.L.T.E there was evidence of 12 of their 41 siblings having died suddenly and unexpectedly (Southall et al 1997). Eleven deaths

had been classified as SIDS. Four parents later admitted to suffocation, 8 of these of siblings. One additional death attributed to rotavirus gastroenteritis was reinvestigated after CVS revealed poisoning of her live sister. The cause of death was later diagnosed as deliberate salt poisoning. Other forms of abuse were documented in the records of 15 additional siblings.

Although there is no reliable way of estimating the possibility that a second death is due to natural or other causes, using statistics or family characteristics, a range of factors are associated with increased risk of sudden infant death although other factors will mediate the risk so that the group is not homogeneous. Smoking, poverty and high parity in young mothers raises the risk of SIDS to 1 in 214 live births, whereas for the rest of the population, the incidence of SIDS falls to 1:8543 live births (RCPCH Guidance 2002). The same factors, associated also with socio-economic and educational disadvantage are found in other forms of child abuse, and are linked also to higher incidence of congenital abnormality, and infections and accidents.

However, the RCPCH Guidance (2002) has drawn attention to problems in the investigation and recording of child deaths, which makes them difficult to research and to reach conclusions about the interrelationship of factors causing them. The Cesdi Survey of infant deaths (1993-96 Published 2000) noted inconsistencies in the definition of SIDS deaths and confusion in the use of terminology and classification to the extent that they reckoned that it was not possible to determine, from current ONS figures, precise totals, either for all sudden infant deaths or for those that meet the Beckworth criteria for SIDS (CESDI STUDY 2000 p3).

In the Southall Study (1997), of the 52 siblings of the 46 index cases, 2 had died: one from hypoplastic left heart at 5 days and one from SIDS at 7 weeks. Valentine et al (1997) report a case of sibling abuse involving 2 sisters. The cause of death for the eldest girl (15m) was, after exhaustive testing, given as asphyxia. The younger

child at 4 months was tested positive for benzodiazepines. The latter child had been removed from her mother at 5 weeks old on the death of her sister and was returned at 4 months. Illness induction began one week after her return to her mother's custody. This type of evidence lends support to there being a compulsive element in this form of child abuse and that it might be serial, with more than one child being targeted. The fact that some children may have a demonstrable disease does not eliminate the possibility of Msbp. Children with special needs are not immune from the abuse. This is a difficult area to recognise and work in.

Gretchen Precey (Manchester MSbP Conference 2002) has drawn attention to the increased vulnerability of *disabled* children and those with complex learning difficulties. Crosse et al (1993) have estimated that disabled children are 1.7 times as likely to be abused as are children without disabilities. In some cases, their difficulties may have been caused or exacerbated by abuse. Precey (2002) has suggested that there are similarities between the adapted structures of families with *disabled* children and families where children are at risk from Msbp.

Precey (2002) argues that in families where a child's illness often provides a focus, the mother assumes centre-stage, particularly if the child's needs are significant, demanding of time and energy. Fathers are characteristically not as actively involved. There is an already established relationship with a professional system, which can be accessed routinely through the case review and surveillance system or in crisis (increased, prolonged or onset of fitting, feeding difficulties, infection etc). Disabled children are also more likely to be accessed physically, by a multiplicity of carers, both within and outwith the home and are therefore more vulnerable to being abused. Signs of abuse may be attributed to their condition e.g. esophageal reflux whereas they may have more sinister aetiologies.

Often, families search for treatments or a diagnosis and may '*Doctor-shop*'. Local charitable organizations send children *to swim with dolphins* as '*a cure*' for Autism

as well as for '*quack*' investigations and *treatments* within and beyond the UK. Professionals, who do not support these methods may face vilification. A professional colleague of the writer's, invited to visit a private organization, based in Scotland, in order to cure her of her skepticism, was firmly told by a lay attendant, escorting her around the premises, that psychologists knew '*nothing about the brain*'. In real terms, she was probably not wrong: however, it is to be hoped that it was qualitatively more than her American employer, subsequently arrested for giving children injections of sheep gland to cure ADHD.

Taylor (1992) has likewise drawn attention to this and how difficult it can be to challenge parents, whose use of fringe medicine harms children. Eminson and Postlethwaite (2000) describe the need to work with and understand parent's belief systems about illness in their children, as a way in to changing their behaviour. Later, will be described a case of symptom fabrication (blood on a baby bib) by an African woman, living in Britain, who *believed* it came to be there '*by magic*'.

Clinicians will recognize these scenarios or similar. They are regrettable in that even when there is no intention to harm *directly*, when parents are desperately seeking explanations or cures, children can be harmed *indirectly*. Precey (2002) makes the point that Doctors may be unwilling or may fail to recognize the spectrum of presentations or '*Doctor-shopping*' in mothers of disabled children as abuse or Msbp. Deaths in this group of children may be difficult to differentiate as natural or unnatural.

Distribution of Cases

The BPSU research group noted a 94.4% return rate to the BPSU in 1994: they do not, however, specify how many of these related directly to their survey or to another condition being surveyed, concurrently, through the BPSU orange-card

notification system. Two hundred and ten notifications were scrutinized, 82 were excluded yielding 128 cases. Cases, where there was no Paediatrician involved or not a P.S.A. member, would not be picked up in the survey nor would those involving children for whom no child protection case conference (CPCC) had been convened, due to death or being no longer at risk.

There were marked differences between regions (0.1 to 0.8 per 100,000 children < 16 years of age), in the number of cases notified, giving rise to speculation as to which variables might be implicated. McClure et al (1996) noted that true regional differences may actually exist. Heightened awareness in some regions accruing to individuals with a particular interest or focus to their work might have contributed to higher than national average incidence levels (Yorkshire 0.8/100,000 (13 cases) < below 16 years of age). By contrast, in densely populated regions (incorporating London) with lower than the national average incidence levels, it was considered likely that a concentration of available Paediatricians, in these health service regions, paradoxically reduced the chances of being caught, '*Doctor shopping*'.

As their conclusion, McClure et al (1996) note that regional variations are better accounted for by under-recognition and under reporting by Paediatricians. This, they attributed to issues in respect of confidentiality and a lack of confidence in reaching a diagnosis. They were supported in their conclusion by evidence that of the 109 notifying Paediatricians, 85% estimated the probability of their diagnosis being correct as greater than 90%, 14 estimated probability as lying between 70-90% and only 1 estimated probability at below 50%. In all of the 8 cases, where a diagnosis was confirmed using covert video surveillance, probability was estimated at > 90% and > 90% probability was given as an estimate in the 13 cases in which children appeared on the child protection register. This prompted them to assert that due to the high level of confidence among Doctors making the diagnosis (which they presumably confirmed) *'it is more likely that Doctors in regions with low reported*

incidences failed to either recognise or notify cases rather than that those in other regions were over diagnosing abuse (p61).'

These concerns will persist in the literature. It is widely recognized that all forms of child abuse are likely to be under-recognised and under-reported. The professional literature will draw attention to the importance of including Msbp in the differential diagnosis of problematic cases, where there is emerging suspicion of fabrication or induction (Parnell and Day 1998, Eminson and Postlethwaite 2000). That this is a psychologically and emotionally difficult conclusion for Doctors, is likewise widely recognized (Schreier and Libow 1993, Motz 2001).

This being said, the results will support other interpretations as well as those offered by McClure et al (1996) who have mainly drawn attention to Doctor competency and under-reporting. These recognise that cases will progress differently through the child protection system and that the entry criterion of a CPCC represents a high tariff for inclusion.

The research group did not consider a spectrum of recognition and reporting by Doctors, mediated by a range of factors not least evidence of harm to a child and whether this constitutes sufficient grounds for a referral to Social Services, whose duty it is to initiate an assessment prior to a CPCC. Social Services Departments are also likely to respond differently to the spectrum of harmful behaviours, which parents perpetrate against their children and that some of these manifestations (e.g. enforced invalidism, being maintained in a sick role with or without collusion, social isolation from being kept at home) are difficult to quantify within the concept of Significant Harm.

Among the different types of child abuse, emotional maltreatment is the vaguest and most poorly defined (Kalichman 1999). Other considerations relate to the timing of a referral – unless a child is in immediate danger – and the importance of

maintaining a relationship with the parent to monitor and safeguard the child, while gathering sufficient evidence to approach social services with concerns. The safety of a child may hinge on the ability of a referring agency to demonstrate to a Social Services Department that a child is *suffering or likely to suffer significant* harm, at a level requiring compulsory intervention. Good practice dictates that parents are informed of referrals to Social Services *unless* further risk to a child is anticipated. This is a judgement call but one which clouds many decisions to refer cases even when there is mandated reporting of child abuse.

Southall et al (1997) have expressed concerns that parents alerted to professional suspicion of the course of a child's medical condition, may attempt to disguise abusive behaviour, further. They have also observed, in practice, that honouring the spirit of *Working in Partnership* with parents may not be easy with a deceptive parent (or family) and may not be in the best interests of a child.

Given this context, the evidence supports conclusions other than under-recognition contributing to under-reporting of cases. This conclusion was predicated on the assumption of continuity of practice across the regions in implementing child protection procedures and in the interpretation and application of the legislation, particularly with regard to what constitutes *Significant Harm*, for which there are no absolute criteria. This might, at best, be optimistic. Some, at least, of the variation in cases clearing the CPCC *hurdle* may also be a function of this and not totally accounted for by the under-recognition and under reporting, by Paediatricians, noted by the research group. They themselves recognised an association between heightened professional awareness in certain regions and increased notifications: it is conceivable that this likewise informed and influenced Social Services Departments in these areas, increasing the likelihood that cases might be accepted as referrals and might proceed to CPCCS.

Footnote: Home Office Department of Health Education and Science. Working Together Act 1989. A Guide to Interagency Cooperation London 1991. See also: The Children (Scotland) Act 1995.

Given that cases are likely to progress differently through the child protection system, the CPCC criterion for inclusion effectively pre-determined which cases would be notified. It is therefore to be predicted that cases notified by Paediatricians, would predominantly consist of those reporting physical harm. This is borne out in the results: of the 128 cases finally accepted for inclusion, 97 involved Msbp. Of this group, 23 involved verbal fabrications alone. No evidence is available for individual cases but it is conceivable that these cases represented verbal fabrications resulting in indirect harm of the children, through unnecessary medical intervention – but this is speculation. Paediatricians responding to the survey noted that they had to be virtually certain of their diagnosis before a CPCC would be convened, which accounts for the level of confidence reported by them in their diagnosis.

This is briefly acknowledged by McClure et al (1996) who note that:
'the finding that the majority of perpetrators of Msbp inflict direct harm on their children is new ..... this finding may reflect that a case conference is more likely when physical harm has been inflicted (1996 p61).'

It is therefore difficult to justify a conclusion which puts much emphasis on under-recognition by Paediatricians or to their not reporting of cases. The following comment by McClure et al (1996) is unsubstantiated by their evidence.

'Due to the high certainty of Paediatricians in their diagnosis, it is more likely that Doctors, in regions with low reported incidences, failed to either recognise or notify cases, rather than that those in other regions were over-diagnosing abuse'.

Child abuse does not lend itself to epidemiological research and incidence levels are likely to be under-estimates, even in rare events. Nonetheless, it is argued that the BPSU (1996) study provides important but *qualified* epidemiological evidence for Msbp, non-accidental poisoning and non-accidental suffocation and their overlap, which while it takes account of the most severe forms of physical harm, does not

recognise that there is a spectrum of harmful manifestations, some of which may be more difficult to substantiate and which may not, therefore, reach a CPCC. While the research group recognise this, they do not give it sufficient emphasis in the analysis of their results.

Some evidence in support of this interpretation of the BPSU Study data comes from epidemiological research carried out in New Zealand by Denny Grant and Pinnock (2001), roughly replicating the BPSU Study.

All Paediatricians in New Zealand were approached, by mail, to notify cases of the same triad of abuse in children under 16 years, encountered within the previous 12 months. The entry criteria were referral to child protection agencies or police or where there was suspicion of abuse but a referral had not been made. There was a return rate of 95% (148 Paediatricians), which yielded 47 cases, 26 of which did not clear the time criterion. The authors concluded that incidence of the triad of abuse in children aged below 16 was 2.0/100,000. Excluding cases not referred, the incidence rate dropped to 1.2 /100,000 children under 16; which was 3 times the rate produced by the BPSU Study (1996). While the NZ Study replicated the presentations and findings of previous studies, one of the conclusions reached by the authors was that they had picked up a wider continuum of cases, *'the majority of which were not severe'* (2001 p242).

The NZ Study also drew attention to the length of time taken to diagnose abuse. They note that the mean time taken to diagnosis from initial presentation was 7 months, in the cases referred to child protection agencies and 23 months in non-referred cases. This suggests that the dawning of recognition is likely to vary with the severity of the abuse and that the gathering of evidence, in any event, may be a slow process, particularly at the less severe end of the spectrum, when evidence of harm might be less apparent.

Mechanisms of Harm and Sequelae

Most medical specialisms or sub-specialisms note cases of Msbp; paediatric gastro-enterology and neurology are perhaps obvious choices, given the dramatic nature of common presenting symptoms (blood in vomit, frequent and recurrent unexplained vomiting, unconsciousness, epilepsy). Schreier and Libow (1993) surveyed 880 paediatric neurologists and 388 gastroenterologists in the United States. Together, they reported 273 confirmed cases of Msbp and 192 seriously suspected cases. They reported that 9.7% of the victims had died.

Richard Newton (in Eminson and Postlethwaite 2000) draws attention to the problem of corroboration in neurological presentations of Msbp making diagnosis difficult. He notes that up to one third of neurological consultations involve CNS symptoms, involving loss of consciousness, where diagnostic possibilities include epilepsy or syncope or apnoea in infants, not confirmed by investigations and not substantiated by an improbable 'history' provided by the mother alone.

Children may be presented to a range of medical professionals, perhaps contemporaneously. Hospital Paediatricians see children presented acutely, their lives saved by prompt recognition and resuscitation (RCPCH Guidance 2002) or, on a longer-term basis through community Paediatricians.

It is contended here that other non-medical specialist, who work with children, may become part of the same processes: For example, referrals to psychologists for developmental cognitive assessments, or for the diagnosis of pervasive developmental disorders (autism, dyspraxia) or, more commonly, behavioural disorders, most notably ADHD. Arguments in support of widening recognition of

Msbp, as occurring elsewhere, have been endorsed by Schreier (1995), who describes a case of false allegations of sexual abuse to police officers, by a mother, against her divorcing husband. In keeping with his general theoretical position, Schreier (1995) sees this as an example of the child's mother seeking a relationship with an important male figure. Schreier (1995) also notes cases of Msbp where school based child psychologists were targeted by mothers. Jones (1996) has argued consistently, that Msbp should be restricted to medical contexts, where its most dangerous manifestations represent the greatest physical risk to children.

Differentiating real from imagined signs or symptoms or, those further down the spectrum of harm, may be complicated where there is an existing medical condition or in cases where an older child has learning difficulties and is unable (or unwilling) to describe what is happening to him. Judith Libow's (1995, 2000) work demonstrates that some children do not become aware of their mothers actions before adulthood.

Enmeshed Cases

Although caution is necessary when dealing with uncorroborated retrospective reporting, Libow's (1995, 2000) work suggests outcomes compatible with those found elsewhere (Bools et al 1992) in terms of short-term and long-term psychological morbidity and behavioural difficulties in adolescence. Her recent work (2002) provides strong evidence of Msbp transmission across generations and of enmeshed parent-child relationships, making it difficult to differentiate between the parent's illness behaviour for the child, collusion, and acute involvement by the child in falsifying illness, subsequently. Cases, as examples, are described here to illustrate the pervasive effect of enmeshed and dysfunctional parent/child relationships and as examples of diagnostic challenges and *'blended cases'*.

Palmer and Toshimura (1984) describe an early case of a mother, who manifested Munchausen Syndrome as an adolescent and as an adult, went on to abuse her child through faecal contamination. Her own childhood had been characterized by an

extensive medical history of abuse, unexplained fractures, failure to thrive, episodic vomiting and medical procedures for investigations of vague symptoms.

Conway and Pond (1995) describe the case of a woman in her late 20s who continued a pattern of fabricating illness begun by her mother, who presented her with factitious cystic fibrosis between the ages of 2 years until she was 11. The woman began later to present herself with abdominal pain and cystic fibrosis from the time she was 17.

Libow (2002) suggests that the '*blended cases*' (collusion) in adolescence, might cast light on' *transitional processes*', which transmit the behaviours within families and which suggest the need to factor in intentional falsification, by a child, when considering unexplainable signs, in medical problems. She suggests that time should be invested in assessing the parent's role, either in colluding with the child or in earlier abuse through illness falsification, thereby preventing '*a life-time career of medical abuse and possible intergenerational transmission of factitious disorder*' (2002 p533).

Libow (2002) advances several important research questions, which relate (in summary) to the need to better understand intergenerational transmission, as well as which child variables make them more vulnerable and whether there is a continuum, through which a child moves from passive victim, through collusion to active independent illness falsification and induction. The lack of prevalence data of Munchausen Syndrome, in adolescence and information about the role of medical services in dealing with child victims and whether or not they inadvertently reinforce the sick role, poses further questions.

Many of the immediate, short-term and long-term outcomes of Msbp bear resemblance to those associated with more commonly found occurrences of child abuse. McGuire and Feldman (1989) reported cases involving infant feeding problems, school behavioural difficulties, conversion disorder* and later fabrications of illness in adolescence. Problems in school attendance, concentration and emotional/behavioural difficulties have been reported years after child protection procedures and involvement (Bools et al 1992). Riggs, Mario and McHarvey (1990) draw attention to the serious long-term psychological outcomes for victims and adolescence, including eating disorders, attempted suicide and alcohol abuse. Steele (1986) reports 'delinquency' and difficulties in sustaining subsequent relationships.

Problems in self esteem and later attachment difficulties assume a central position in the aetiology and pathways towards emotional and behavioural problems in childhood and into adulthood. *Learning* about the psychological value and gratification to be had from *being ill*, as in the intergenerational transmission of Msbp may also have its roots here, as will other repeating patterns of child abuse. Steele (1986).

Jones et al in Eminson and Postlethwaite (2000) have linked the effects of maltreatment with the interrupted development of individual competency across the life-span, but crucially in the childhood and adolescent years. Psychologists would recognise the term to refer to social understanding and interaction, emotional intelligence and maturity, organisational skills and the development of positive relationships. Clearly, this is not a prescribed list but one, which recognises *competency* over a range of domains, which might broadly predict good outcomes in adulthood, in a contemporary western society.

Footnote: A manifestation of psychosomatic illness, in which the patient may not be able to walk or may experience sensory loss not attributable to any conditions but having its roots in psychological disturbance or stress

Whether a child independently falsifies illness or colludes as in *'blended'* cases or takes over the illness scenarios, it is argued here that the child is no less a victim from being involved in his or her own harm. Evidence that adult Munchausen Syndrome often begins in disordered behaviour in adolescence (Reich and Gottfried 1983) points to its origins in problematic relationships within the family, and more particularly the need to overcome feelings of powerlessness and lack of control (Libow 2002).

Very little literature exists for children, manifesting Munchausen Syndrome in themselves. Libow's review (2002) suggests that while there is a spectrum of manifestation, induction and self-harm being the more frequent and clearly intentional, nothing exists to explain their independent role in illness falsification. She speculates, however, on issues of power and the need to achieve a sense of control and personal agency, which it is suggested here will bear comparison with the onset of adolescent disorders such as anorexia nervosa, in which a child uses food and subsequent refusal to eat, as a mechanism of gaining some control over his or her life.

Adult victims have reported significant emotional and behavioural difficulties in childhood, including depression, post-traumatic stress disorder (in both the induction and fabrication of symptoms by parents) and feelings of insecurity. Many have independently sought psychological help and report feeling doubtful about interpreting signs and symptoms in themselves and whether they should seek medical advice. Above all, Libow (1995) reports that most of the adults interviewed (albeit a small sample of 10) were aware of not being loved by their parents, of being unsafe. Those, who approached other adults for help were ignored: what emerges from a reading of the literature is the sense of loss of childhood and the relationship with the perpetrator, most significantly, the child's mother. Later

psychological problems and behaviours involving illness falsification, as a transmitted pattern of behaviour, are likely to emerge from a child's early experience of parenting and the interpersonal dynamics between care-taker and child (Libow 2002), which lies at the core of child development.

The Spectrum of Harm and Risk

The use of Msbp of F.I.I. is not to describe a category of parental abusive behaviour, narrowly defined by motivation but instead recognises a spectrum of parental behaviours in seeking health care for a child, ranging from adaptive to maladaptive Eminson and Postlethwaite (2000). Msbp is shorthand for direct harm to a child as a sequel to parental fabrication or induction of signs and symptoms of illness or indirect (iatrogenic) harm brought about through the involvement of health professionals and unnecessary investigations and treatment, as sequelae, to the mother's actions.

Donald and Jureidini (1996) have described the context for severe abuse, noting that it is more likely to happen when the medical system is specialized, investigation-orientated, fascinated by rare conditions, often ignorant of abusive behaviours.

The dangerousness of this triangulation of abuse, makes the assessment of continuing risk to a child, essential (Jones et al in Eminson and Postlethwaite 2000); in particular, whether the child should remain with its mother. This will largely be determined by the type and severity of the abuse. Meadow, alone (1995) and in collaboration (Bools et al 1994), has emphasised the dangerousness of mothers, who abuse their children by fabricating or inducing signs and symptoms. Bools et al (1994), Meadow (1990) and Southall et al (1997) have drawn attention to the immediate danger presented by smothering to produce symptoms.

Jureidini (1993) has drawn attention to the case of a mother poisoning two children in succession, once one child was permanently removed from her care, evidence that she had tried to harm the younger child, in utero, prompted child protection procedures and intervention, when she became pregnant with her third child. Bluglass (1997) has highlighted the importance of working with the mother, after separation from one child, for the benefit of the second child.

Eminson and Postlethwaite (2000) have gone as far as to suggest that more Paediatricians has led to increased opportunities for Msbp abuse within paediatric settings. One of the cornerstones of their argument, is that the relationship between Doctors and patients has changed, characterised by increased patient power to make demands on the health services for investigations and treatment so that '*the bargain*', by which children are brought to Doctors has changed. It has become difficult to say 'No' to anything. This, however, is not unique to medicine and would be recognised by a range of professionals working with children.

Verbal fabrications, which occur alone, represent the mild end of the spectrum, and are more common that induced illness and are known to be frequent (RCPCH Guidance 2002). This being said, the potential for harm is here, if verbal fabrications are persistent and the child grossly misrepresented. They may also represent a snap-shot of wider problematic family functioning amidst which other children may be vulnerable.

In the writer's own case experience, a mother, who was constructing the profile of her first child as autistic, offered information to his Head Teacher, during interview that her second child (at approaching school age) was doubly incontinent and had mobility problems. When checked with the community Paediatrician, there was no evidence in the child's surveillance notes to support this. Following a multi-professional decision that no one would refer to this again, the child entered school, as a normal healthy school-girl. The third child has significant learning difficulties.

Although there appears to be very little evidence to support progression across the spectrum of abuse (Eminson and Postlethwaite 2000) it remains possible that a mother may escalate harm (Parnell and Day 1998). Studies have shown that siblings, within families, may experience different forms and severity of abuse as can the index child, as shown in the UK (BPSU) Study (1996) and in the work of Southall et al (1997). Valentine et al's (1997) case notifications involving two female siblings, one fatally suffocated and one poisoned evidences that mothers may abuse children, differently, within her own family.

It is perhaps too soon to take the view that verbal falsification, alone, is relatively less harmless, since not enough is known or understood about the likely long-term outcomes for children of Msbp and very little information is available from adult survivors (Libow 2002). What evidence there is, suggests that there are likely harmful developmental and psycho-social outcomes for the child, who embraces the mother's view of her /him as being sick (Taylor 1992) from enforced invalidism (Taylor 1992) accruing to the social isolation from being kept away from school and their peers and the interruption to childhood activities (Smith 2000).

Schreier and Libow (1993) have drawn attention to cases of psychogenic behaviour in children, who have gone on to maintain illness symptoms in the absence of a parent. Earlier were described cases of Munchausen Syndrome in children (Tec 1995, Sneed and Bell 1976, Mitchell 1987). Libow (2000) and Sanders (1995) have suggested that in overly enmeshed mother-child relationships, among the older group of child-victims, there may be collusion to preserve the relationship with the mother or because the child believes s/he is ill and accepts the mother's version of events unable to distinguish real from artefactual symptoms (Sigal et al 1989).

Challenging and changing parental *beliefs* about their children can be difficult, even when the alternative is a better outcome.

Green (2000) describes the case of a 14 year old boy presented with '*total allergy syndrome*' which coincided with media attention to this condition. He was taken to various conventional and alternative health practitioners. One clinician supported the family's belief in the boys condition, which remitted when he spent four months in hospital. The boy had demonstrated no distress, opposition to his parent's views or a desire to get out of his predicament. Once discharged, characteristically, he and his family did not continue with the therapeutic work being undertaken to alter their beliefs in his *illness.*

These cases point in the direction of grossly distorted parent-child relationships. There is no way of predicting how the psychological distorted '*self image*', which this may lead to, will affect their own later parenting skills (RCPCH Guidance 2002) and the further transmission of the behaviour.

It has been argued here and throughout that Msbp, as a manifestation of child abuse, is better understood as a *process*, which recognises a variety of origins and pathways, of inter-relationships of factors, both distal and proximal and of different outcomes for victims (Jones et al 2000). This developmental/ecological explanation is recognised in the work of Reder and Duncan (1999), who have applied this as a model to describe the mechanisms of fatal child abuse and by Jones et al (in Eminson and Postlethwaite 2000) as providing a model for the assessment of risk, particularly in severe cases of Msbp.

Jones and Bools (1999) have noted intergenerational and problematic attachment between mother and child, in turn linked with childhood histories of abuse and deprivation, personality difficulties and conditions such as depression. From these factors can be extrapolated domains for assessment (child, parent, parent-child, family, social and professional) and the transactions between them (Jones et al 2000). More immediate risk assessment may relate to the need to establish and

preserve the safety of a child. This is determined by the type and severity of the abuse, the level of parental acknowledgement and cooperation with immediate intervention strategies and longer term therapeutic work and the identification of factors, which might increase or decrease the risk of further maltreatment and above all the assessment of the relative likelihood of change.

Libow's (1995) work with adult survivors has provided some evidence that Msbp abuse only stopped when they were old enough to disclose or left home and that siblings were also abused, supporting findings that the behaviour is compulsive, continuing at some level when the child is returned home (Bools et al 1994). There is anecdotal evidence of parents trying to induce illness in their adult children and that denial may be life-long (Libow 1995). Bools et al (1994) have shown that even when confronted with incontrovertible evidence of abuse (CVS recordings) there is denial. Fabrications might extend to different types of falsified dramas (house-fires, victims of crime etc) or other victims (nursing home residents). Libow (1995) describes case scenarios, in which child-victims as adults continued to believe they had been ill until tests (for Tuberculosis in one case) proved otherwise. Rosenberg (1987) has also commented that *'the fact that the parents have been confronted does not preclude the possibility of subsequent murder of a child'*. (1987 p557).

The mechanisms of harm, in conjunction with the nature and severity of the presenting symptoms, age at on-set and the timing of intervention (diagnosis/recognition preceding this) will largely determine the severity of harm to a child from illness falsification (RCPCH Guidance 2002). Further equally damaging harm exists in a child's experience of disordered parenting and factors in the life-style leading to other forms of abuse. In a study by Bools, Neale and Meadow (1992) 73% of the index victims of Msbp had experience of one or more forms of abuse including other examples of non-accidental injury, a history of failure to thrive, neglect, various fabrications and being given inappropriate medication. Apart from immediate harm to a child, which may be life-threatening,

the long-term psychological sequalae of a distorted childhood and of an uncaring maternal relationship are pervasive. To this extent, the mechanisms and processes of abuse are as relevant and clearly contribute to cases involving collusion and inter-generational transmission.

Rosenberg (1987) first described the spectrum of harm drawn from a literature review of cases between 1966-1987. Twenty years on from this very important paper, a literature review of 605 cases has been described by Eminson and Postlethwaite (2002) compiled from individual case notifications and case series. This was incorporated into the RCPCH Guidance (2002) and is reproduced here, since it is impractical to describe the range of Msbp manifestations other than in tabular reference form. This is referenced in an appendix with sources (Appendices 1 and 2). (Reproduced by kind permission of the RCPCH).

Their analysis clusters cases into clinical categories based on the level of physical intrusiveness (RCPCH Guidance 2002). They were as follows:

1. verbal fabrications, fabrication of test results but no direct induction. This category is broad and includes bleeding, apnea, seizures, infections etc.
2. withholding nutrients
3. production of signs and symptoms other than by poisoning or smothering
4. poisoning of low toxicity (emetics, laxatives and diuretics)
5. poisoning of high toxicity (insulin, salt, bleach, prescription drugs, arsenic etc)
6. apparent life threatening events (ALTE – smothering)

They drew the following conclusions. There were surprisingly few deaths reported in category 6 but the risk to siblings and the index child increased concomitantly with increased physical intrusiveness. Verbal fabrications started in early childhood

as did the onset of other forms of illness falsification but the age, at which this was identified was older than for other forms of abuse. This is not a surprising finding given that the more serious manifestations of physical harm will provide a higher degree of medical concern and are, therefore, the more remarkable and more likely to be written up. That illness falsification has its onset in early childhood can be taken as further evidence of problematic parenting, associated with attachment difficulties. Verbal falsifications were also associated with tampering with charts on wards and fabricated symptoms (blood on nappies, vomit on bibs etc).

There was *no evidence* supporting progression along a continuum although it *remains possible* that some parents may have begun with verbal falsifications (Parnell and Day 1998). A combination of different types of falsification can occur at the same time, as can different types of abuse. This analysis did identify groups of parents, who never crossed the threshold into illness induction. Five per cent of abuse was carried out within the context and circumstances provided by intrinsic illness in a child.

The few males, who perpetrated Msbp abuse, did so at the severest end of the spectrum. Related physical and sexual abuse increased with physical intrusiveness. Again, this is not surprising since *abusive families* can present multiple sources of risk to their children.

Finally, the RCPCH Guidance (2002) states that Doctors are not innocent bystanders. The review concluded that 13% to 68% of the surgery, across the different categories, was unnecessary and involved long pre-surgical procedures. In 29 cases the abuse to the child was '*an iatrogenically produced portal of entry to the body*' (2002 p25) e.g. gastrostomy.

Factitious Psychiatric Presentations and Developmental Disorders

There are few cases in the literature of factitious presentations of psychological (psychiatric) or developmental disorders in childhood, for example, Autism, Gilles de la Tourette Syndrome, although there is recognition that children are now increasingly being presented with a range of conditions: Allergies (Meadow 1982), Autism, ADHD, Tourettes Syndrome, (Green 2000). With the publication of Madelaine Portwood's book on Developmental Dyspraxia, child psychologists encountered increased demands from schools and parents for assessment, whereas 10 years ago, it was comparatively unknown. Media and public preoccupations with specific conditions can lead to parental health beliefs (Bools 1996) about children, which are difficult to challenge within a child protection framework, and which might not be *factitious* by their very nature. The consequences for the child are varied in severity but have been associated with restricted normal development, disrupted psycho-social functioning and stress, as described above. Proving emotional abuse, is, however, difficult.

Green (in Eminson and Postlethwaite 2000) has described the problems inherent in defining psychological and emotional abuse, which essentially stem from the interpersonal context of symptomatology in child psychiatry (and psychology), which is why clinicians working in this area tend to favour a systemic intervention approach, which constructs the problem to be resolved within the context of wider family functioning.

From a retrospective case-note study of children presented for assessment of '*neuro psychiatric*' disorders (Tourette's Syndrome and Autism), Green (2000) concluded that families, where the decision was of factitious disorder bore comparison with perpetrators of Msbp physical harm. Multiple illnesses had been described in this group by carers and early relationship difficulties with the child were noted in 2/3 of the factitious group. Over protectiveness was the most striking finding and Green

(2000) provides the example of a healthy boy not allowed to play outside due to maternal fears that he might have a heart attack or another of a 4 year old boy kept infantilised by being kept in nappies, in spite of being toilet-trained. This small sample survey also supports the findings elsewhere of poor marital relationships, of a disengaged father and maternal depression. (Schreier and Libow 1993).

Characteristically, families coming to therapy bring different stories and, therefore, there can be distorted histories or unverified accounts of children's difficulties or symptomology, in psychiatric terms. This is bound by the various contexts, in which children live and exist. A child demonstrating extreme hyperactivity at home (by parental report) may not do so in a classroom where controls are consistent and well defined for the child and where adult behaviour is predictable and *even*. Applying the label Msbp in these contexts would be widely inappropriate. Establishing the phenomenology of mental illness in children is less certain than establishing physical harm and abuse (Green 2000).

Factitious Sexual Abuse

This is a difficult area and one more commonly associated with custody disputes and attempts to antagonise a partner (Kelly and Loader 1997). Schreier (1996) reports one of the earliest American cases, in which a mother falsely accused her husband of the sexual abuse of their 1½ year old son. Although separated, this was a malicious fabrication, which had nothing to do with custody and went on for months until a court threatened to take the child away. This is an unusual manifestation of what Schreier (1996) reports as parents drawing '*other agents of power*', who deal with children, into the Msbp process.

Meadow (1995) has advised caution in interpreting the motivation of mothers, who make false allegations of sexual abuse, particularly in acrimonious marital situations.

The Evidence In Relation to Maternal Psychopathology

As discussed above there is no profile of a Msbp mother perpetrator (or, any other perpetrator). The evidence to date (Bools et al 1994, Southall et al 1997) points to the more significant implication of clusters of risk factors.

The use of psychological and psychometric testing has established no personality profile (Schreier and Libow 1993, Parnell and Day 1998). The most common presentation of the Msbp mother-perpetrator is of an individual, *who displays no overt indications of psychopathology or disturbed parent-child relationship (Parnell and Day 1998 p130)*

The research by Bools, Neale and Meadow (1994) provided the first systematic study of the psychiatric histories and status of a group of 47 mothers, known to have fabricated illness in their children. These represented the severest forms of abuse – smothering, poisoning and other forms of physical harm to the extent that 59% of the families had had a child removed, subsequent to child protection procedures. There were 10 child deaths of uncertain cause. Thirty of the 47 mothers fitted the label of '*active inducers*' (Schreier and Libow 1993), suffocation was more quickly identified than poisoning, which typically began less acutely and was often preceded by less harmful fabrications. It is also less likely to be immediately recognisable, particularly when not suspected by Doctors.

Most of the mothers in the sample originated from social classes III and IV and were generally not from economically derived homes. At the time of the fabrications, the mean age of the mothers, who were interviewed, as part of the study (19) was 25 years. Six, who poisoned, had a mean age of 27 and 2 had been over 30. Fifteen had been married at the time of the abuse. Interestingly, at the time of follow-up (for some cases this represented years after the original abuse) they remained married to the same husband. This study also drew attention to the characteristic of continuing

denial, which makes maternal behaviour resistant to change and provides potential continued risk to a dependant child from further direct or indirect harm, as already stated.

The main conclusions of the study relate to the finding of a high incidence (15) of *somatising disorders* among the 19 women interviewed. Ten manifested Factitious Disorders; pulling hair out and claiming it was a disease, factitious diabetes, haematemisis, ante-partum bleeding and renal stones. In 10, this was chronic and long-standing and began in childhood. Three had had unnecessary surgery. In all, 12 had histories of self-harm, 7 of substance abuse and 5 women had learning difficulties, although there is insufficient information to draw firm conclusions about what this means in terms of severity.

In terms of their psychological functioning, 14 of the 19 mothers met the criteria on the Personality Assessment Schedule for Personality Disorders. Histrionic and borderline personality disorders being prominent among women, who actively induced illness. Only 3 of the 19 mothers interviewed had well-defined disorders excluding personality disorder. These were an eating disorder, a possible psychotic illness and hypochondriasis. Three others demonstrated psycho-somatic complaints. Nine of the women had been involved with the police for, among other crimes, offences involving fraud (1) theft (4) and arson (3).

These results bear comparison with the family histories of perpetrators in the study carried out by Southall et al (1997). Again, this group represented the severest end of the spectrum of abuse, involving 39 children referred for CVS investigation of Apparent Life Threatening Events (ALTE) to two major hospitals in England.

In this study, 23 out of 39 mothers were diagnosed by psychiatrists as manifesting personality disorder. Twenty five fabricated or induced illness in themselves, 17 made false allegations of sexual abuse or rape. Childhood histories were

characterized by being problematic. Ten mothers were reported with severe behavioural problems and criminal behaviour was noted in 9. The co-morbidity of siblings is strongly evidenced in this study: Nine mothers had a sudden unexplained infant death, ingestion of drugs or toxic substances was suspected in 4 children and proven in 1. As in the study by Bools et al (1994) 29 of the mothers were over 20 years at the time of the abuse and 23 had a partner, of which 19 were married. Three of the families were associated with house fires, 2 falsely alleged to be a nurse and had been investigated for animal cruelty.

In the absence of test data, the finding of Personality Disorder in both studies has to be taken at face value although replicated elsewhere (Famularo et al 1992). The definition of Personality Disorder is problematic and diffuse and the forensic use of psychological testing (Psychometric and Personality Assessment Tests) as predictors of future behaviour of *offenders*, comparatively useless. They may in some circumstances inform decisions about the risk to children (Bluglass: Conference 2002) but other mediating factors (acknowledgement, family support and cooperation with treatment and therapy) are probably more salient and central, as noted above.

Here and as noted by Parnell and Day (1998), caution is advised in the use of personality assessments and '*the categorisation of personality types*' (p129). This assumes one size fits all, whereas there will be variations within offender groups. Parnell and Day (1998) draw on evidence that among sexual offenders 'normal' profiles on the Minnesota Multiplesic Personality Inventory (MMPI) is a common finding. Parnell's (1998) own use of MMPI with 15 Msbp mothers revealed no particular pattern of scores to indicate any unifying mental conditions or characteristic psychopathology.

There are few studies offering psychometric or personality profile assessments of Msbp mothers. There are no population based comparison studies to test whether

the profiles of Msbp mothers have any discriminative validity or can be used in diagnosis (Mart 2002) or to predict risk of future harm (Bluglass 2002). Those, which have been centre stage in shaping the Munchausen mother profile are now qualified although, in their time, influential.

Schreier and Libow (1993) draw on their clinical experience of Msbp cases and a battery of psychometric and personality assessments (WAIS-R, MMPI/MMP1-2, Thematic Apperception Test) available for 12 women to offer the following conclusions:

' ..... these mother-perpetrators had a poor fund of general information and a superficial level of social adeptness and lacked comprehension of the more abstract concepts underlying the social world'. (1993 p173).

and,

' .... Poor abstract conceptual abilities, superficial social skills, and outgoing behaviour. This is coupled with a rigid denying defensive style masking a underlying rebelliousness, emotional immaturity, selfcentredness, lack of social conformity and intense passive resentment' (1993 p185).

Problems in small sample size and the fact that some women willingly cooperated with the assessment whereas others were ordered to attend, confounds the results and any interpretation, thereafter(Parnell and Day 1998). Also the battery of tests was not uniformly administered and test protocols were obtained from colleagues. Also although all 12 women completed the WAIS-R, only 9 completed the MMPI – one completed the revised edition-MMPI-2, and 8 completed that Thematic Apperception Test. Although this shrinks the sample size further, apart from this, there are clear problems in drawing conclusions from tests, which offer different assessment approaches. This leads, in turn, to concerns about Schreier and Libow's (1993) interpretation of sub-test results on the WAIS-R, in particular those items tapping social competency and understanding (Mart 2002). It is argued here that they are very liberally interpreted by Schreier and Libow (1993) who have drawn

conclusions which would not have been available from the test results. The WAIS-R is a test of adult intellectual ability, which although incorporating tests of social understanding (for example, picture arrangement sequencing events) offers scores of cognitive ability, from which personality profiles cannot be extrapolated. However, this would fuel debate between different branches of psychology.

Interpreting test data, provided elsewhere can be inherently problematic, since the clinician interpreting the results is unable to add any qualitative analysis which might have become available during the test situation. Mart (2002) advises particular caution in the interpretation of MMPI data absent corroborative background case details, which might explain the outcome. This is particularly pertinent in the use of the MMPI since it is possible to produce faked responses, which mask personality flaws (Mart 2002).

By way of an example in illustration of the finding of *defensiveness in parents*, Mart (2002) references the work of Bathurt et al (1997). They investigated the MMPI protocols of 508 child custody litigants (an American practice not emulated in the UK) and concluded that *defensiveness* in parents involved in custody battles, not associated with Msbp, was more the norm than the exception and reflects scoring artifacts. The *defensiveness* observed in Schreier and Libow's (1993) sample does not differentiate them from other parents involved in custody battles or engaged in other forms of child abuse and may or may not represent attempts to disguise or mask underlying problems (Mart 2002).

However, Bentovim et al (1994) and Green (2000) suggest that mothers, who have experienced spousal abuse may have developed diffuse or confused boundaries, leading them to believe that the child may have experienced the same. An alternative interpretation is available from the work of Shipman et al (1999), which

has shown that there can be co-occurrence of spousal and child abuse and that careful assessment is required before the possibility is excluded.

Accounting for Maternal Behaviour

The recognition of similarities in the behaviour of Msbp mothers in hospital settings, engendered theoretical perspectives as to their motivation (Schreier 1993, 2000), which in turn gave rise to speculation as to whether these women were suffering from a mental illness. What seemed to be a *perverse* corruption of the maternal role led to thinking that there must be something wrong, some form of female psychopathology. This view has been reinforced by the strength of maternal denial, even in the presence of incontrovertible evidence of abuse. This is a recurring theme in the literature (Schreier and Libow, 1993, Meadow 1995, Jones 2000) and has been shown to persist into the child- victim's adulthood (Libow 1995).

Motz (2001) has suggested that both an inability to accept that women can harm their own children and, a denial of female violence has led to the ready acceptance of their psychological disturbance. The pathologising of women's behaviour across the centuries is described by Allison and Roberts (1998) and extensively in the feminist literature (Chester 1972). Showalter (1987) has examined issues of gender in concepts of madness and has provided a feminist history of psychiatry and a cultural history of madness *as a female malady*. Showalter's work looks at how, in particular, cultural contexts and gender influence the definition and, consequently, the treatment of mental disorder. However, there are better ways to describe women, who abuse their own children, which do not hinge fundamentally on concepts of mental illness or observation or diagnostic formulations but which take account of the various factors, which scaffold an individuals behaviour, along the various pathways to abuse.

Since Msbp occurs in medical settings, it has been wrongly assumed to be a *diagnosis* with a *single* and *causal* explanation, in keeping with medical explanatory models (Eminson and Jureidini 2003). This assumes a single aetiological variable of maternal psychopathology, and motivation, evidenced by a consistent and definable pattern of presentation and unique characteristics, which can be identified outwith medical contexts. Eminson and Jureidini (2003) cast doubt on whether this is true of Msbp perpetrators. They draw parallels with other forms and patterns of physical abuse and argue that explanations for Msbp belong in the epistemology of sociology, not of medicine (2003 p415). Fisher and Mitchell (1995) expounded this view nearly a decade previously.

Defining a pattern of presentation and unique characteristics (Eminson and Jureidini 2003, p414) in the shape of behavioural profiles of perpetrators, particularly in hospital settings and the use of diagnostic criteria, has been widely criticised as being neither sensitive nor non specific and subject to misinterpretation (Morley 1995). This has been described above, in reference to the diagnostic criteria advanced by Meadow (1994), Samuels and Southall (1992) and (Bools et al 1994).

In shorthand, these describe paradoxical behaviour on hospital wards, by parents, who appear to enjoy becoming part of the life and routine, in spite of having a sick child, lying nearby. The fabrication of signs and symptoms, in the child on the ward maintains this contact as the diagnosis is pursued. Schreier and Libow (1993) describe this in theatrical terminology, which identifies actors and their roles.

Diagnostic criteria such as those proposed by Rosenberg (1987, 2003) and Meadow (1995, 2000) include the need to establish the temporal association of the mother with the abuse. More credibly, risk factors in the perpetrator, including those associated with: abnormal illness behaviour in parents for themselves or psychiatric illness, evidence of fabrications involving other people (and pets) and life-style *dramas,* alcohol or drug abuse, problematic relationships and social contacts and

socio-economic stressors are implicated. This very comprehensive list of risk factors is comparatively meaningless absent any explanation of how they interact: there is likely to be no single causal pathway or 'profile' of risk.

The rarity of Msbp abuse may point to there being particular features in maternal functioning, which if exacerbated (or triggered) by specific combinations of risk factors, may lead to Msbp abuse. Reder and Duncan (1999) have identified a strand in cases of child abuse, which relate to *the meaning* of the child at a given time, in the life-cycle of the mother and the family, as acting as a potential catalyst for abuse.

The medical literature draws attention to the importance of somatising behaviour in Msbp mothers (Bools et al 1994), Davis (Conference Presentation 2002). Research into the somatising behaviour of parents has been identified by Eminson and Jureidini (2003) as a more productive research area, particularly in predicting future risk to children. They also see value in a systemic approach, which takes account of individual historical '*domains*' of past experience, behaviour and mental health, and current and past family as predictors of availability for support to change.

Psychodynamic explanations account for maternal behaviour in terms, which recognises their need for recognition and the benefits, in this respect, of presenting *in the perfect mother role;* which is a role seen as central to Msbp (Schreier and Libow 1993), and is a reflection of the idealisation of motherhood in society. (Motz 2001). While this provides the forum (for the drama), psychodynamic theory will describe the mechanisms in terms, which describe the need to form a relationship with a powerful male figure (Doctor) for the fulfilment of unresolved (intra-psychical) needs. Schreier and Libow (1993) suggest that the false perception on the part of others, who believe these mothers' versions of events and believe them to be caring on the one hand, differentiates Msbp from other forms of child abuse and on the other, clouds recognition and identification, prolonging the harm to their children, who mean less to them, as children, than as objects. The uncovering of the

deception has psychological and emotional implications for the Doctor(s) involved in the case.

Concepts of transference and projective identification (Green 2000) are widely recognised in the psychological literature on Msbp. Motz (2001) draws heavily on these aspects of psychodynamic theory as well as attachment theory in her work on female violence. She argues that violence committed by women, against their own bodies and their children, represents important *tools of communication* (2000 p6).

Women, who use their or their children's bodies in this way, are likely to have experienced disturbed early attachment patterns. Motz (2001) describes intergenerational patterns of deprivation and abuse, which predispose women to abuse their own children, and which cause them to direct their aggression on to their own bodies or their children's to provide solutions. The mechanisms, which support cycles of abuse relate to the experience of mothering, social stresses and life choices including partners. As often seen in clinical practice, Motz (2001) describes a progression from obsessed girl to partnership with an abuser, further loss of control and learned helplessness. Applied to cases of Msbp, she emphasises the link between maternal *aggression* (intra-psychical) and *victimisation* and the need to take account of the mother's internal script of unmet need and psychological disturbance. On a hospital ward, a mother acting out the script feels valued and listened to and somatises her own psychological pain on to her child either through fantasy (verbal fabrications) or violence (induction).

There is widespread support for explanations embedded in problematic attachment as described above. One of the conclusions reached by Southall et al (1997) in their investigation of life threatening child abuse was that the emotional and physical harm inflicted by mothers on their children reflected '*a severely dysfunctional relationship between parent and child*' p739. Evidence of mothers own poor

parenting experience and reported abuse caused them to draw further conclusions about intergenerational transmission of patterns of abusive behaviour.

The research by Southall and his colleagues (1997) was highly significant in demonstrating the value of covert video surveillance (CVS) detecting a hitherto unknown range of abuse carried out in hospitals, by mothers, against their children. Their results indicate that abuse has many layers and that women, can perpetrate terrible immediate and long-term harm on their children. To this extent, Southall et al (1997) concluded that the abuse inflicted by the parents, observed in this study, bore close comparison with mothers, who perpetrate non-Msbp physical abuse of children.

The first epidemiological research established females as the main perpetrators of Msbp abuse (Rosenberg 1987). More recent literature reviews (Eminson and Postlethwaite 2002) have described 313 cases, in which the perpetrators was the child's mother in 89%, a substitute e.g. (foster-parent) in 3% and a male in 5%. A recent literature review of cases published between 1972 and 1999 has yielded 451 cases in 154 journal articles (Sheridan 2003). This has produced interesting variations which indicate that while women continue to be the main perpetrators (76.5%) the next largest group are fathers (6.7%). There was no victim gender bias reported by Sheridan (2003) among women whereas men were 3 times more likely to abuse their sons. A speculative interpretation of this finding might be that men are extending their repertoire of abusive behaviours, as public awareness and knowledge of the mechanisms of Msbp abuse expands. Equally well will paternal abuse of male children be explained by psychodynamic paradigms. Men, who perpetrate Msbp abuse, are more likely to be suffering serious psychiatric illness at the time of the abuse than are female perpetrators (Eminson and Postlethwaite 2000).

There is a fairly consistent finding that the bulk of female perpetrators are older at aged between 20-35 years (Bools et al 1994) and that the majority are married at the time of the abuse (Light and Sheridan 1990).

Socio-economic Distribution

There is sparse literature on social class distribution. All classes are represented but a study by Light and Sheridan (1990), in which the majority of the parents were receiving welfare payments, highlights the vulnerability of children in economically poor families. Although poverty, *per se*, may not account for the abuse, it may point to life-style risk factors, which in an interactive effect, might offer explanations.

In the research carried out by Bools et al (1994), 13 of the 19 women whose backgrounds were examined were categorized in social classes 3-5 (albeit, based on husband's occupation).

There is likewise a spread of educational achievement (Schreier and Libow 1993). An analysis of 110 cases by Bluglass (2002) suggests that perpetrators tend to fall into the low average ability range. Eleven of the these mothers also provided significantly low intelligence scores.

The Beverley Allitt case gave rise to the urban myth that nurses, as a professional group, are over-represented in perpetrator populations. The RCPCH Guidance (2002) quotes an overall figure for perpetrators with paramedical or nursing training of 7%. Msbp abuse involving nurses as perpetrators is more often associated with serial abuse more often than not resulting in death (Davis 1993, Elkind 1989). Sheridan (2003) has recently noted that 14.0% (N=28) cases of Msbp involved a perpetrator employed or with training in a health-related profession: 28 were nurses and 13 were nursing assistants. Some women with somatising disorders in themselves or the need to appear and be valued as a carer of children, may be drawn

to employment in hospitals. This may lead to overly enmeshed relationships with a child and blurring of boundaries between the self and the child so that unresolved issues in the adult's own childhood are triggered by that child.

Green (2000) refers to this as '*projective identification*'. In a parenting context, parents come to believe that their own experience (often a trauma) exists in the child. In presenting the child for care they are acting out the care, which they wished from their own parent. The child becomes the '*by proxy*' component. This is compatible with psychodynamic theoretical perspectives, such as that advanced by Schreier (1993) whose emphasis has always been on a Freudian slant based on *transference* to a powerful male figure. Explanations centred around maternal child enmeshment are compatible with theories of child development and infant attachment. They provide comprehensive explanations for the range and severity of Msbp manifestations of abuse and the complications of collusion.

Green (2000) has noted that children exposed to such intense (psychodynamic) feelings and who can observe evoked distress in their mother, can become disorganized and *symptomatic*. In extreme examples, this represents a failure of parenting and a major child protection issue. However, as noted above, this is often difficult to describe and justify particularly to colleagues in child protection services, who have no formal psychology training.

A Wider Perspective

As described above and discussed, recently, by Eminson and Jureidini (2003) confusion about what Msbp is, since it occurs in medical settings, has provided persistent misunderstanding that a mother *has* Msbp, as an illness. Msbp is a *paediatric conclusion* derived from evidence of harm to a child and is not dependant

on a psychiatric label for the perpetrators. The research carried out by Bools, Neale and Meadow (1994) also demonstrated that there may be clusters of characteristics associated with Msbp but no profile. Their finding (and that of Southall et al 1997) that the majority of mothers in their study demonstrated a form of personality disorder, does not make personality disorder an axiomatic pointer to Msbp child abuse or any other form of child abuse (Bluglass: Conference 2002). In this regard, the *presence* or *absence* of personality disorder or a better defined psychiatric disorder e.g. depression may be less useful in the assessment of risk to a child than acknowledgement of the abuse. (Jones et al 2000).

One factor determining future safety is the availability of the father and wider family to protect the child. This is crucial in situations considered borderline in terms of the psychopathology and stance of the mother (Pearce and Bools 2000). If the father and/or family do not recognise and acknowledge what the mother has done to the child, the child is less likely to be safe-guarded against future abuse, left in her care. Establishing a working partnership with other family members becomes extremely important both for surveillance and, in mediating the long-term effects of the abuse.

A developmental and ecological perspective is a widely accepted framework, in which to consider child maltreatment and should provide the foundation for assessment and intervention (Pearce and Neale (2000) and has been recommended elsewhere (Jones et al 2000 Eminson and Postlethwaite (2000) and influences the approach taken here. This approach shifts the focus from concerns about individual maternal psychopathology to the need to look at systemic factors in the family. While there are benefits to the child for prevention and establishing risk and to the mother, in identifying and addressing her needs for psychological understanding and help, this *alone* will not account for the behaviour.

The literature draws attention to abnormal illness behaviour and somatising disorders in mothers in themselves (Griffith 1988, Meadow 1995, 2000, Bools et al

1994). Griffith (1988) suggests that Msbp, which he describes as a 'systemic syndrome' is more likely to occur when a woman with somatising behaviour, for herself, enters a family where there is already exploitation of children.

This finding of abnormal illness (somatising) behaviour among women perpetrating Msbp is an important one. This is defined as: *'the persistence of an inappropriate mode of perceiving, evaluating and acting in relation to ones health' (Bluglass 2002)* and is consistent across all of the systematic studies of the severest forms of abuse: (Bools, Neale and Meadow (1994) Leeds; Gray and Bentnovim (1996) Great Ormond Street Hospital; Southall and colleagues (1997) Staffordshire and London. There is no comparable research carried out in Scotland but the work of Stephenson (1990) in Glasgow is noted.

Family Factors

At various points in the discussion, models of risk for child abuse have been described. These recognise that abuse is a process and that individuals are more or less affected by these processes, across the life-span, dependant on other variables. Inter-generational abuse (repeat) patterns more than likely point to the insidious effects of emotional abuse in childhood. In families in which there is poor communication or understanding about feelings, perhaps compromised through intellectual difficulties, or in which the child's needs are not recognized, physical symptoms may come to be recognised as a currency to elicit care from a parent. In some cases, this may be a learned response. The adult lives, particularly of women whose early experience is marred by emotional deprivation, may be characterized by seeking fulfillment through taking control of the lives of others, for whom they have responsibility. Health Care settings nurture their own need for care and recognition (Eminson and Postlethwaite 2000).

Both in Munchausen Syndrome and Munchausen Syndrome by proxy somatising behaviour serves a communicative function (Menninger 1934, Schreier and Libow 1993, Motz 2001) and represent distorted beliefs and perceptions about one's own body and the boundaries with another. This is also emphasised by evidence of obstetric factitious disorder (Jureidini 1993). A past or current history of somatisation and high unexplained levels of unexplained symptoms in pregnancy have been identified as providing an important current focus for research (Eminson and Jureidini 2003) as well as maternal experience of emotional abuse and neglect, physical and sexual abuse, self-harm and alcohol/substance abuse. (Reder and Duncan 1999).

The women in the case series reported by Southall et al (1997) presented with seriously distorted life styles, problematic psycho-social functioning and abnormal illness behaviour in themselves. In this context, a child may represent an added burden or may be unwanted (Reder and Duncan 1999). A lack of maternal empathy (Eminson and Jureidini 2003) and/or attachment difficulties (Jones 2000) or parenting difficulties stemming from her own childhood experience (Gray and Bentovim 1996) may render a child vulnerable when there is poor separation and differentiation of need between mother and child.

Summary Conclusions

- Msbp is a rare event: however, with increased recognition has come better understanding of the range and spectrum of manifestations and harm, perpetrated against children. As in other forms of child abuse the '*true*' incidence is unlikely ever to be known.

- Msbp is *a psychiatric label* for the perpetrator in the medical classification system but is better understood as a *paediatric conclusion* evidenced by harm to a child.

- Harm can be through direct maternal action or indirect *iatrogenic* harm.

- Modern paediatric practice in respect of history-taking, access to wards etc is implicated in Msbp child abuse as is increased parent power.

- Msbp should form part of the differential diagnosis, in cases in which children are over presented with inexplicable, medically illogical signs and symptoms.

- Definition *by motivation* constrains aeteology within concepts of maternal psychopathology. No unified model has emerged from the literature. Personality Disorder has been identified as a consistent finding but is non-specific.

- Abnormal illness behaviour/somatisation is also a consistent finding, particularly among women, who perpetrate the most serious forms of abuse (smothering and poisoning). Somatisation behaviour links Munchausen Syndrome with Munchausen Syndrome by Proxy but does not explain the mechanisms by which somatising behaviour in oneself becomes child abuse. Systemic, interactional models provide a more appropriate framework for describing individual and family functioning, where child abuse is an outcome.

- Individual temperamental factors interacting with a matrix of factors both historical and present, the perceived status of mothers in paediatric settings, an absence of psychological nurturing and support from a partner or family and the meaning of a child within the life cycle of its mother or family may be implicated.

- Cycles of child abuse are significantly associated with chaotic dysfunctional life-styles and multiple layers of risk and vulnerability. There may be poor empathic understanding of the needs of family members, particularly children and lower than optimal (for child development) levels of social functioning and individual competency.

- The long-term sequelae of maltreatment and emotional abuse in mothers represent major risk to their subsequent children and contribute to inter-generational abuse and a lack of differentiation between the self and the child in terms of the resolution of needs.

Finally future research will aim to identify risk factors and strategies for intervention in the pathways, which might lead to Msbp child abuse. The following areas have been identified as axiomatic.

- maternal somatising behaviour and mental health
- unexplained signs or symptoms in the obstetric history
- the epidemiology of *milder* forms of Msbp
- maternal perceptions about the health of their children and family belief systems about illness
- mother-infant attachment studies
- the identification of triggers. Why is a child being presented now?
- The availability of medical resources and support to vulnerable families
- Ways of reducing iatrogenic harm brought about through inadequate clinical history-taking and a lack of attention to the detail of parental psycho-social functioning, as part of the wider picture of the child.
- coordinated health care to reduce opportunities for abuse.

(Adapted from (Eminson and Jureidini 2003).

CHAPTER 5

Background To The Research

Munchausen Syndrome by Proxy (Msbp) will be used consistently in reference to what has been described as a rare manifestation of child abuse and does not refer here to the psychiatric status of the *perpetrator* of the abuse.

The British Paediatric Unit Survey (McClure, Davis, Meadow, Sibert 1996) continues to provide the benchmark epidemiological data. This study reported a combined incidence for the United Kingdom and Republic of Ireland of non-accidental suffocation and non-accidental poisoning, in children under 16 years of age, of 0.5/100,000. When cases of non-accidental poisoning and non-accidental suffocation, not presenting as Msbp were excluded, this provided an annual incidence of 0.4/100,000 children under 16 years of age.

A survey carried out in New Zealand in 1999 by Denny, Grant and Pinnock (2001) provided an incidence level of Msbp, non-accidental poisoning and non-accidental suffocation of 2.0/100,000 children under 16 years of age.

The BPSU study (1996) revealed wide variations in incidence levels between health board regions, from 0.1/100,000 to 0.6/100,000 children under 16 years of age. These might represent real differences or procedural variations, as described above, to produce *missed* cases.

The BPSU Study (1996) reported 3 cases in Scotland, which were accepted as matching the study criteria, providing an incidence level of 0.3/100,000 children under 16 years of age. Apart from the work of Stephenson (1990) in Glasgow, there is no research reported in Scotland, in the professional literature, which could be located through a survey of the core computer bases.

The criterion of Significant Harm (Children (Scotland) Act 1995) remains a subjectively defined and diffuse area in child protection work and one, which falls

essentially to Social Services Departments to determine. It therefore signifies an important transition point in professional recognition of *potential* or *actual* harm to a child. This is less challenging in cases representing the severest end of the abuse spectrum, where harm and risk to a child may be more obvious but is moreso in cases, in which harm may be difficult to define or quantify, particularly between professional groups. Defining *Significant Harm* when a child is repeatedly smothered or poisoned with salt is qualitatively different and often more straightforward than defining harm to a child, repeatedly presented factitiously as ill, but where there is no evidence of actual induced or fabricated illness. The concept of *Significant Harm* very much pivots on immediacy, and struggles to accommodate concerns about long-term morbidity, particularly when in relation to psycho-social and emotional effects of abuse.

Professional recognition is an important variable contributing to under-reporting. Increasing numbers of cases, in the literature, suggest that there is widening awareness of diverse presentations and *the spectrum of harm*. There may be continuing misunderstanding of perpetrator motivation (DSM IV T-R 2000) and psychological functioning: however, the recent Guidance on Fabricated or Induced Illness by Carers (F.I.I.) (Royal College of Paediatrics and Child Health 2002), provides clarity in the use of the preferred terminology and its emphasis on F.I.I. as a paediatric diagnosis, evidenced by harm to a child.

In spite of inherent difficulties in the definition of what constitutes *Significant Harm*, cases crossing its threshold will be of an evidenced level of seriousness so as to possibly require compulsory measures of intervention with the family, by Social Services and possible removal of its child/ren. In the context of Msbp, the concept of *Significant Harm* can provide a marker, by which to measure professional recognition of the spectrum of abnormal illness behaviour in parents for their children, where any hypothetical threshold might lie, as well as providing information about the extent and manifestations of harm, which children are subjected to. Reaching a shared professional understanding of this may demystify Msbp and clarify child protection work at case-work level as well as informing risk

and prevention. The aim of any research should ultimately be to improve the welfare of children through *early enough* intervention.

The Research

Over a decade has elapsed since the BPSU (1996) Study reported the incidence of cases of Msbp, non-accidental suffocation and non-accidental poisoning, in children under 16 years of age, in Scotland. The aim of this research is:

- to determine the likely current incidence level of Msbp within the Scottish under 16 population
- to describe the spectrum of harm, which these cases represent
- to provide qualitative information about professional understanding and roles
- to outline further research strategies and recommendations for improving professional practice

Methodology

A mailing-list of Paediatricians, working in Scotland, was compiled from the membership of two professional associations (BACCH/SACCH)[1] and from a list of Scottish Baspcan[2] subscribers. The RCPCH[3] mailing-list was unavailable for this research. Paediatricians were asked to confidentially nominate cases, of which they had had direct clinical experience, within the previous year, which matched the following working definition:

> *Munchausen Syndrome by Proxy (Fabricated or Induced Illness) is a form of child abuse, in which medical conditions may be fabricated, falsified and/or exaggerated in a child by an adult carer. Condition should be broadly interpreted. Typically, a child will be over-presented to medical services and may be subjected to an extensive range of medical tests and interventions. The child may have a pre-existing condition. Importantly, the behaviour of the presenting adult(s) may have raised professional concerns, particularly in terms of motivation.*

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[1] British (and Scottish) Associations of Community Child Health.
[2] British Association for the Study and Prevention of Child Abuse and Neglect.
[3] Royal College of Paediatricians and Child Health

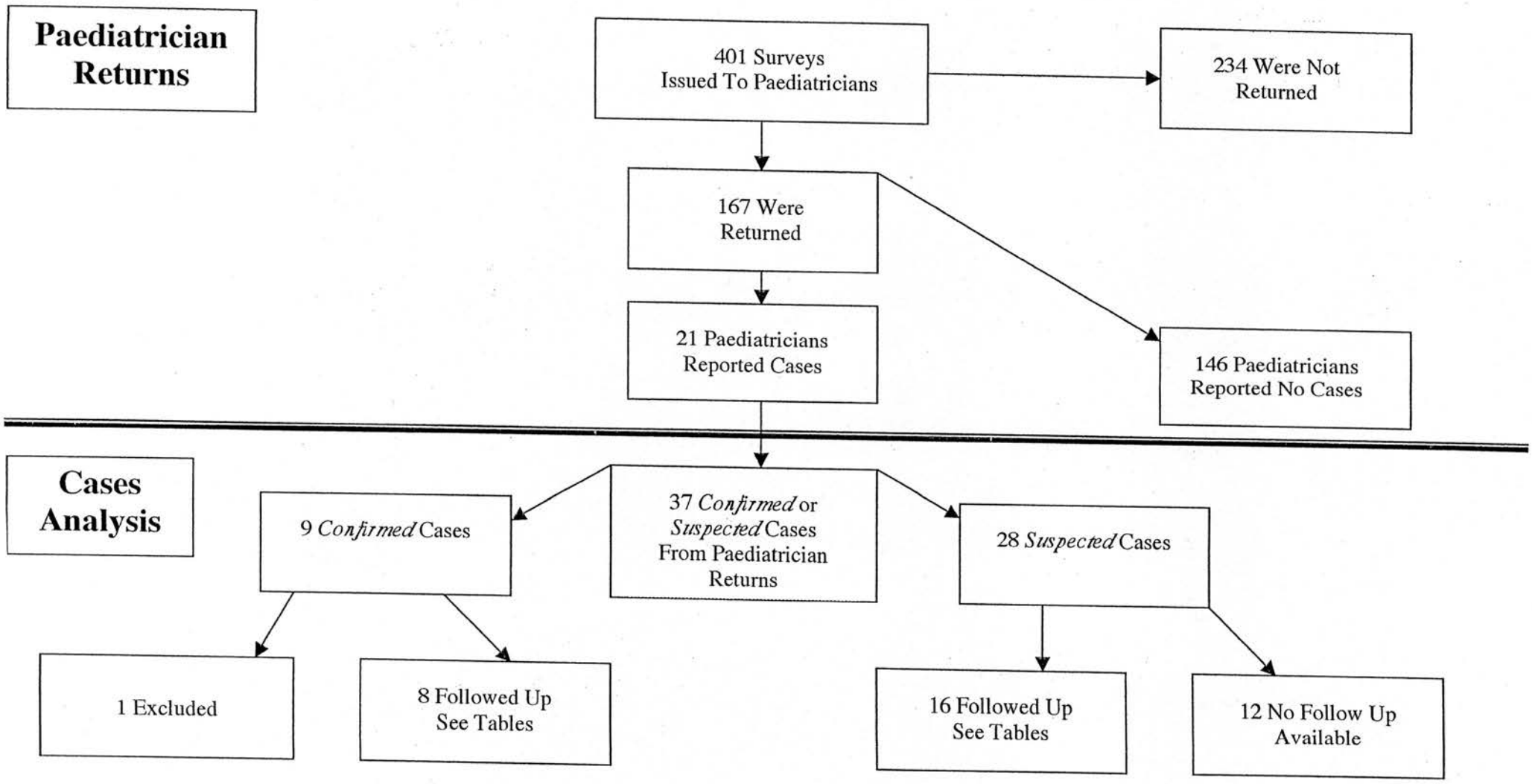
They were also asked to nominate those cases, in which Msbp was *strongly suspected.* Those Paediatricians, who had nominated cases and had indicated a willingness to contribute further to the research, were interviewed using a semi-structured interview proforma (appendix 3): by choice, either directly or by telephone.

Results

401 Paediatricians, who were either community or hospital based specialists, were contacted, by mail, in the first stage of the survey. Responses were received from 167 (41.6%). One hundred and forty six returns provided no cases. Twenty one Paediatricians reported 9 *confirmed* cases of Msbp and 28 *suspected* cases. One community Paediatrician felt unable to be interviewed and asked that the senior Paediatrician, in his particular health region be contacted. This case was excluded as *not* matching the inclusion criterion of *direct clinical experience.* Of the 28 notified suspected cases 12 provided no information at follow-up. One Paediatrician notifying 1 suspected case and one Paediatrician notifying 3 suspected cases indicated no further contact. Three Paediatricians together notifying 6 suspected cases could not be contacted by telephone or messages, left over a period of time. One specialist Paediatrician withdrew due to private concerns about breaching patient confidentiality.

All but two of the Paediatricians, willing to proceed, were interviewed using the semi-structured interview schedule (Appendix 3). Two were visited and interviewed. This information identified overlaps since children's names were never used beyond initials and no other signifiers were available. Two separate confirmed cases very obviously overlapped. Both were identified, simultaneously, by a community Paediatrician and a paediatric specialist. One senior paediatric specialist was anxious that there should be no signifiers, which might identify him to *colleagues.*

Survey Returns



Confirmed Cases of Msbp

Of the 8 *confirmed* case of Msbp notified by Paediatricians, 5 of the cases involved girls and 3 boys. Four children were presented at less than 1 year old. Three children at age 5 and one child (8) was presented over 3 years until the abuse was eventually recognised as hypernatraemia associated with salt ingestion at age 8. One child (2) was presented at age 9. Child (1) was presented at age 5 and was monitored by the Paediatrician for 10 years.

Perpetrator Characteristics

In each case, the mother was thought to be the sole perpetrator. In only two cases (3, 8) were the fathers ever seen. In one case (1) the natural father had not been aware of the pregnancy. In case (7) no information is available about the father and, in the remainder of cases, the father was either separated from the mother or uninvolved in the family. The mother, alone, presented the child in all cases except two (3, 4). In case (3) the mother was accompanied by the father and in case (4), she was accompanied by a female friend, who corroborated the story of the child's symptoms. The mother was thought to be the sole perpetrator in case (3).

Three of the mothers were aged between 21-30, 3 between 31-40 and one was older than 40. Their employment histories are not available. The mother of child (1) had been training as a nurse. One mother from an African country was an asylum seeker (6).

Presenting Signs and Symptoms

One child (1) had a pre-existing condition and had been diagnosed with de Soto Syndrome. Child (8) was thought, by one paediatric specialist, to be suffering from an extremely rare form of developmental ataxia. Two children were presented with seizures (1, 4) and one child (2) was presented with a range of problems including haematuria, deafness and soiling. Child (7) was removed from her mother's care following a history of exaggerated symptoms and investigations of '*all of the major systems*' and in case (6) there were frequent emergency call outs reporting (fabricated) bleeding in the infant. Cases (3) and (8) represent the most acutely

serious abuse being induced apnoea in a very young infant and salt ingestion leading to hypernatraemia and stroke.

The information about the length of time to discovery is variable since the Paediatrician interviewed may not have been the only one involved across the history of the case. The pattern, which emerged, indicated that acute presentations are identified more quickly in children as being abuse, than those, which emerge from exaggeration or fabrication of signs and symptoms, other than induced apnoea. Child (8) had been presented from 3 years before suffering a stroke and child (1) was monitored for 10 years until moving on to adult services.

Siblings

Information is available for cases (4) and (5) and for a third sibling, case (2). Child (4) was presented with 'seizure-type episodes' which were investigated over 18 months. A second sibling (case 5) presented with reported haematemisis at age 5. A retrospective analysis of the case-notes revealed that this child had been presented between the ages of 6 months to 2 years of age with recurrent vomiting. A third sibling (case 2) was presented with reported seizures at below 2 years of age.

Mortality

No deaths were reported.

Outcomes

Case 1	continuing involvement with Social Services
Case 2	on-going case
Case 3	on-going case
Case 4	discharged
Case 5	discharged
Case 6	received into care prior to being returned home
Case 7	received into care
Case 8	child severely disabled. Mother in prison. Child, as a young adult is now asking for explanations from doctors as to what happened to her and why.

Suspected Cases of Msbp

Sixteen *suspected* cases of Msbp matching the inclusion criteria were notified by 9 Paediatricians.

Child Victims

Eleven of the children were female and 3 were male. The sex of two children was not recorded. Ages on presentation were available for 13 children. Ten were 3 years old or below on presentation and 4 were one year or below. Three children were presented older at ages 4, 5 and 7 years, respectively. Only one child presented with a pre-existing condition of cerebral palsy.

Perpetrator Characteristics

Eleven mothers were suspected as the sole perpetrators, who presented all of the cases apart from 5, 6 and 16. One mother (case 2) was also the mother of confirmed cases (4 and 5) above. Foster parents jointly presented cases (5 and 6). One mother presented 4 children (cases 10 to 13 inclusive).

Mothers were generally older. Three were between 21-30 at the time of first presentation and 6 were aged between 31-40. Two were older than 40. Very little information is available about their employment status. Two were employed. One is known to have been a nurse (case 14). No specific detail is available for the other mother, who fostered children (5) and (6). Many of the families lived on benefits and Disability Living Allowances allocated to their children.

Somewhat characteristically in Msbp cases, the pattern is of an absent father except in cases (4, 5) where both foster-parents acted in concert and (6). In case (6) the father was described as a 'vague' man with his own health problems. The mother of children (10-13) had multiple partners, none of whom was involved, significantly, in rearing the children. One father was described as working away from home and one was dead.

Presenting Signs and Symptoms

Seizures were reported in 9 of the 16 children and was the most commonly reported sign, occurring *alone* in 6 cases. Three children were presented with allergy-related conditions. One group of children (10-13 inclusive) were presented with, among other ailments, muscular/skeletal problems, producing reported pain and immobility. One child (10) in this family was provided with a wheelchair in spite of being ambulant and one (13) was strapped into a baby buggy to emphasise his mobility problems.

Pervasive developmental disorders are represented here. A number of presentations relate to developmental disorders and psycho-social functioning in the child. The mother of child (4) pursued an Autism as well as a Schizophrenia diagnosis and child (12) was investigated for Tourette's Syndrome.

Other presentations relate to constipation, hallucinations, impetigo, unrinary tract infections, neurological problems, Attention Deficit Hyperactivity Disorder (ADHD) and incontinence.

One child (16) had had neurosurgery. The children reported with seizures underwent EEG/MRI examinations. Eight of this group were prescribed anti-convulsant medication. The mother of child (4) sought an operation to resolve her child's constipation problems. This was refused by the paediatric gastroenterologist.

Case No	Sex	Age on presentation	Period of involvement with medical services	Presenting signs and symptoms	Professionals involved	Substantiated case history. Family/carer issues	Outcomes
1	F	5 years	10 years. Presentations since birth	Seizures. Rectal bleeding. Sexual abuse (Hymen ruptured, vaginal dilation).	Paediatric Neurology. Developmental Assessment Centre. Social Services. Police	Problematic maternal background. Alleged sexual assault by 3 uncles. Left home when 15. Litigious (2 civil actions raised). Died when child 14.	Aggressive and sexualised behaviour towards wider family, including females. 'Angelic' in school. Problematic adulthood.
2	M	9 years	Frequent presentations since 9 months (on-going)	Chronic fatigue. Soiling. Pain on urination. Haematuria. Kidney pain.	Paediatrician. Child and Family Psychiatry. G.P. Social Services. School. Reporter to Children's Panel. Solicitors for mother.	Sibling investigated also (negative medical results). Iinvolved M.E. support group. Mother frequently prescribed Valium for anxiety.	Child living at home. Attends school. Special needs curriculum. Denied abuse.
3	M	Less than 2 months	6-9 months (on-going)	Induced apnoea. Apnoeic attacks.	Paediatrician. Social Services. Police	Mother suffering depression. Father was away a great deal. Child received into care. Psychotherapy for mother. Child reintroduced to family within 1st year of life.	Child well. Living at home. Denied abuse.

					Paediatrician. Paediatric Neurologist. Police. Reporter to the Children's Panel. Social Services. School/Nursery	Undiagnosed condition in mother rendering her wheelchair bound since 18. Alleged sexual assault by own father. Overdose at 15. Child's father left the family	Child well. Denied abuse.
5*	F	6 months	18 months – discharged	Recurrent vomiting. Haematemisis.	Paediatrician. Gastroenterologist. Social Services. Police. Reporter to Children's Panel	As overleaf.	Barium meal. Endoscopy. Child well. At home. Not presented beyond 2 years. Denied abuse.
6	M	Less than 1 year	On-going	Fabricated blood.	Paediatrician. Child Support Services. Police	None available. Asylum seeker. Explained blood through references to *magic*.	Paediatrician worried about continuing risk to child but removed from Child Protection Register and returned home. Two recent admissions to hospital for ENT concerns. Denied abuse.
7	F	5		Over-presentation. Exaggerated illnesses	Paediatrician. Orthopaedics. (Specialists across country) Court in England.	None available. Traversed country with child, doctor shopping. False names when returned to Scotland.	Child received into care. Denied abuse.
8	F	5	12 years on-going	Ataxia. Poor eating. Chest infections. Hypernetraemia.	Paediatrician. Paediatric Neurologist. Gastroenterologist. Social Services. Police. Criminal Justice System. School.	Fabrication and Exaggeration for self (breast cancer).	Salt ingestion. Stroke. Severe disability. Mother in prison. Denied abuse. Seeking an appeal.

Case Summaries

Case 1 This child had a diagnosis of de Soto Syndrome but with average intelligence. She was in and out of care from birth and was in care when her mother died. No siblings. Her mother accused the child's father of sexually abusing her but this was never substantiated. There was a history of attachment difficulties and problematic parenting. The mother verbally maligned the child and physically assaulted her. There was evidence of collusion as the child grew older. Severe behavioural difficulties, which she could produce to order, encouraged by her mother. Her mother responded well to 3 years of therapeutic in-put and the presentations lessened during this period. As a young adult, there is a continuing need for Social Services to provide support for independent living in the community.

Case 2 This boy was presented with a range of minor illnesses. He did have genuine and regular throat infections and had had a tonsillectomy. Frequent absence from school has resulted in lowered attainment and the need for a specialist modified curriculum.

Case 3 This child was presented frequently to Accident and Emergency with apnoeic spells, which were unsubstantiated, although both parents presented the child, the mother was suspected of being the sole perpetrator. The child presented as well on investigation. There was fabricated *and* induced apnoea. Possibility of post-natal depression, which abated following support and psychotherapy.

Case 4 This child was presented in early infancy with reported seizures, corroborated consciously or unconsciously by a female friend, who accompanied her to the hospital. She was put on medication until she was 2_ years old when the possibility of fabrication arose. The mother would not back down on the issue of the seizures but medication was nevertheless withdrawn.

Case 5 This child (sibling of case 4) was presented from 6 months. Presentations stopped after 2 years of age. Both children (plus one other sibling) were monitored for a period of time but are now discharged.

Case 6 This child was presented with fabricated blood on his face and clothing, later shown not to be his. Raised levels of concern for this child persist but in spite of this, he was removed from the child protection register, considered no longer at risk of harm. In this example, the notifying Paediatrician pointed to the importance of using interpreters when the parent's English is poor.

Case 7 This child was taken up and down the country. Exaggerated illnesses and fabrication. Child played happily at school but was often put in a buggy by her mother and wheeled around. The child was frequently absent form school and had extensive periods of hospital admissions for investigation of leg pain and problems. This mother tracked medical professionals so as to identify and avoid them and she also used false names when joining G.P. practices. Child freed for adoption.

Case 8 This child began life normally but deteriorated and later presented with a developmental delay in infancy. She was also wrongly diagnosed with a rare and terminal form of developmental ataxia. She eventually walked and intellectually made progress. She settled well into primary school but with frequent unsubstantiated illnesses. The child did not eat well. Her packed lunches were inadequate and school noted a pattern that when it was reported to her mother that she had eaten well that day, she was kept off ill, subsequently. School was concerned about being asked to administer medication from unlabelled bottles. Concerns were raised by a children's hospice about the child's care. A gastrostomy peg was eventually fitted. The child was repeatedly presented with raised sodium levels until suffering a stroke at age 8. Although there were historical concerns about the child over years, expressed by a range of services, the delay in considering a conclusion of induced illness, attributable to salt ingestion, was provided by the earlier diagnosis, which diverted attention away from the possibility of abuse.

Suspected Cases

Case No	Sex	Age on presentation	Period of involvement with medical services	Presenting signs and symptoms	Professionals involved	Substantiated case history. Family/carer issues	Outcomes
1	F	7 years	3 years	Constipation. Impetigo. Multiple minor complaints.	Paediatrician. Gastroenterology. Reporter to the Children's Panel. Child and Family Psychiatry. Social Services.	Parenting difficulties. Exaggerated illnesses in family (stomach cancer).	Extensive non-attendance at school.
2	F	Less than 2 months	On-going	Seizures.	Paediatrician.	Mother of confirmed cases 4 and 5 above. Mental health problems noted.	No seizures when separated from mother.
3	F	3 years	12 years on-going	Seizures.	Paediatrician. Social Services. Paediatric specialists.	No information.	Severe behavioural difficulties.
4	F	2_ years	3 years on-going	Constipation. Seeking Autism diagnosis or Schizophrenia diagnosis.	Paediatrician. Social Services.	No information.	No information.
5	F	4 years	3 years on-going	Foetal Alcohol Syndrome. Seizures. Auditory processing problems.	Paediatrician. Neurology. Genetics. Social Services. Specialist Counselling Centre.	No background information. Older woman and husband with no natural children. Litigious. Younger sibling experienced fractures when younger associated with physical abuse.	Child resents image of her as disabled.

Case No	Sex	Age on presentation	Period of involvement with medical services	Presenting signs and symptoms	Professionals involved	Substantiated case history. Family/carer issues	Outcomes
6	F	5 years	3 years on-going	Seizures.	Paediatrician. Social Services.	Same.	No information.
7	F	-	No information (adopted)	Seizures.	Paediatrician. Social Services.	Poor attachment. Alcohol abuse. Multiple partners.	Freed for adoption.
8	F	-	-	Seizures.	Paediatrician. Social Services.	Same mother as 7. Own child now with Cerebral Palsy and Epilepsy	History of behavioural difficulties.
9	-	Infant	10 years on-going	Seizures.	Paediatrician. Social Services. Child and Family Psychiatry.	No information about mother. Poor history and corroboration. Suggested seizures be videoed – did not comply	Anti-epileptic medication prescribed. Now being weaned off. Behavioural problems.
10	F	6 months	Into adulthood on-going	Failure to thrive. Asthma. Seizures. Back Pain. Eneuresis. Hallucinations. Frequent Accident and Emergency attendance.	Paediatrician. Neurology. Rheumatology.	Highly problematic with evidence of neglect, physical abuse and fabrication of illness in 4 children. Psycho-social deprivation. Eldest child surrogate pregnancy by mother's partner.	Over-medicalisation. Disrupted education. Entered special education. Psychological effects of being constructed as physically disabled.

Case No	Sex	Age on presentation	Period of involvement with medical services	Presenting signs and symptoms	Professionals involved	Substantiated case history. Family/carer issues	Outcomes
11	M	3 years	Into adulthood on-going	Fractures. Seizures. Back pain.	Paediatrician. Neurology. Social Services.	Same mother.	Presenting in adult services for epilepsy.
12	M	18 months	Throughout childhood	Behavioural difficulties. Accident and Emergency aged 2 – blood in stool. Investigated ADHD. Tourette's Syndrome. Muscular pain. Incontinence.	Paediatrician. Rheumatology. Social Services. Specialist behavioural support provision.	Same mother. Partner bruised child when aged 3. Mother assaulted this partner. Gave this child Diazapam. Sought Ritalin but not prescribed. Possible sexual abuse of child.	Constructed as ill. Extreme behavioural difficulties resulting in a specialist school placement. Hyperactive/not ADHD. Conduct Disorder. Reported stress-related seizures after school meetings.
13	-	2 years	On-going	Infantilism. Back pain.	Paediatrician. Social Services. Rheumatology.	Same mother. Wanted to keep child in buggy.	No information.
14	F	-	On-going	Allergies. Urinary tract infections. Swelling/bruising to mouth.	Paediatrician. Immunology specialist.	Mother a nurse. Child self-inflicted bruising using a bottle.	No information.

Case	Sex	Age on	Period of involvement	Presenting signs and	Professionals	Substantiated case	Outcomes

15	F	3 years	10 years on-going	Multiple allergies. Asthma. Urinary tract infections.	Paediatrician.	Mother seeking referrals to specialists.	Good progress in school. No other information.
16	M	Infancy	8/9 years	Neurological problems. Feeding/stomach problems.	Paediatrician. Neurologist. Gastroenterologist.	Pre-natal diagnosis of Spina Bifida. Various neurological symptoms	Severe behavioural difficulties.

Case Summaries

Case 1 This child was presented, historically with constipation. Exaggeration of symptoms -'*not moved her bowels in two weeks*'- but her abdomen would be soft on examination. The mother presented the child alone and although she was described as having a partner, he was never seen. This mother was in the 40+ age range.

Case 2 This child is the sibling of confirmed cases (4) and (5). One seizure was witnessed in hospital but thereafter the frequency was exaggerated by mother. Mother was herself in hospital for a prolonged period, during which no seizures were witnessed or reported in the child.

Case 3 This child has an element of learning difficulty but otherwise copes well. In spite of no diagnosis, her mother continues to do the rounds of doctors and tells them her child receives anti-epileptic medication. Adult neurological services are investigating recently reported patterns of seizures. Child manifesting severe behavioural problems towards mother.

Case 4 This child was originally presented with constipation, for which the mother sought an operation. This and concerns that the child might be autistic or schizophrenic have been challenged by the Paediatrician. This case is on-going.

Case 5 This child lives with her female sibling (case 6) with foster-parents. She is one of 4 children born to a mother with alcohol problems and has been frequently presented by her foster parents for assessment of foetal alcohol syndrome. She and her sister (6) have contact with their 2 other siblings, who are reared by other family members. Child (5) and (6) have been freed for adoption. This child's difficulties, particularly intellectually, are exaggerated by her foster-parents. Both attend meetings and are litigious: legal action against Education Department. They construe the child as disabled. Social Services broadly recognise Msbp but in the absence of

direct harm to the child, wish to maintain the placement with the foster-parents.

Case 6 This child is the sibling of case (5) above.

Case 7 This child was presented with epilepsy as have been 3 other children in the family, across generations. This child's epilepsy was not substantiated.

Case 8 This child is the sibling of case (7). Her reported epilepsy was not corroborated. Her elder male sibling was also presented with breath-holding episodes of unknown cause. There is possibly an element of learning difficulty in their mother. Once epilepsy was discarded as a diagnosis in each child, she asked doctors if '*they could still have fits, anyway*'.

Case 9 This child has been presented for 10 years with reported seizures, uncorroborated. Her mother purports to have evidence but does not provide witnesses etc. when asked. The possibility of illness falsification has been raised with Social Services (avoiding the use of terminology) but they have not taken this up as a child protection concern.

Case 10 This child was presented across her childhood years as ill and disabled with a history of failure to thrive. At age 4 she ingested her mother's anti-depressants. At age 5 she was admitted to hospital due to asthma. She was prescribed increasing doses of anti-epileptic drugs, based on her mother's description of seizures, otherwise unsubstantiated. MRI/EEG tests were carried out. Steroids were administered for joint and back pain at age 12 and an investigation under anaesthetic. She was fitted with a wheelchair in spite of being able to play and dance in school. School staff raised concerns with hospital staff to no effect. Between 1988 and 2001 she experienced 21 Accident and Emergency attendances and 8 x-rays. Falls and a punch to the face were reported. Social Services became involved when school staff raised concerns about non-attendance.

Case 11 This child is the brother of case (10). This child experienced physical abuse (bruising and two arm fractures). At aged 2 he was admitted to hospital for laxative ingestion. At age 3 he and his sister were admitted together having ingested anti-depressants. At age 4, he was again admitted unconscious having consumed anti-depressants. At age 7 he was admitted for a neurological investigation after his mother claimed he was having night-time seizures and was ripping his night-clothes. By age 13 he was also being investigated by a Rheumatologist for back and muscle pain. By 2000 he had attended the Accident and Emergency Departments 11 times. His mother demanded specialist school transport.

Case 12 This child is the brother of cases (10, 11). There are indications of possible sexual abuse. When presented at aged 2 to an Accident and Emergency Department with blood in his stool, his anal area was swollen. It was claimed he had fallen in the shower. His step-father projected a 'macho' image and kept fighting dogs. The boy was bitten twice aged 11. He is a boy of average ability who was placed in specialist behavioural support provision. His mother has not been able to parent him or cope with strategies to support him, at home.

Case 13 This is the 4th child in the family, sibling of cases (10, 11, 12). Repeated investigations by various orthopaedic specialists have uncovered no evidence of illness. Demands for a buggy to transport the child were met. Extensive use of baby-talk due to under-stimulation. Four visits to Accident and Emergency Departments with minor injuries.

Case 14 This child demonstrates an element of collusion in the fabrication of signs of allergies, particularly swelling of the lips.

Case 15 This child's mother has sought multiple referrals to clinicians. Poor communication between the G.P. and Paediatrician has enabled this to happen. The Paediatrician discussed the possibility that signs and

symptoms were being exaggerated or fabricated with Social Services. They would not take up the case due to lack of evidence.

Case 16 This child was born with Spina Bifida. Recurrent problems have led to neuro-surgery. His posterior fossa has been depressed. He has also had back surgery and further neurological operations to counter '*more and more*' symptoms. The boy's behaviour is very difficult to manage and his parents blame the operations. A formal complaint has been raised against a doctor. This boy's pre-existing condition made it difficult to disentangle real from fabricated and falsified symptoms. His mother is a regular visitor to the hospital and a key member of parent support groups.

Discussion

This was a small scale piece of research aimed at providing an incidence level of Msbp in Scotland and to sample those cases, which are illustrative of harm done to children through parental abnormal illness behaviour. There are consequences in terms of physical, psychological and emotional damage (Taylor 1979) accruing to persistently being presented to medical services. Harm can either be *direct* or *indirect* and, therefore, *iatrogenic*, associated with unnecessary treatments or interventions. The cases described above provide such examples, as well as of co-morbidity in siblings (Bools, Neale and Meadow 1992). Eight cases were identified as confirmed *Msbp*. Paediatricians, in consultation with medical colleagues, came to the conclusion in each case. The sole perpetrators were the children's mothers. In keeping with the case literature, fathers were characteristically *absent*, literally or psychologically not engaged in the presentation of the child/ren to medical services, except in one case.

Msbp is considered to be a rare event. Therefore, Paediatricians were asked to report cases with which they had had direct clinical experience over the previous 5 years (2000 – 2005), in order to elicit a spread of presentations to describe the spectrum of parental abnormal illness behaviour. Paediatricians were interviewed in 2006. The year 2005 was taken as the cut off point, at which incidence was calculated. Four of

the cases were excluded as not meeting the time criterion of on-going involvement during the previous year. In one case, the Paediatrician had maintained contact with the child over 10 years, into adulthood, and closed the case when she retired, although it remains open to social services.

Based on the figures of the General Register office of Scotland, taken at mid 2005, the total number of children under 16 years of age is 985,987. Four confirmed cases met all of the inclusion criteria. This provides an incidence level of *Msbp* of 0.4 per 100,000 children. This provides only a slight increase of 0.1/100,000 population under 16 years of age over the BPSU study (McClure et al. 1996), which identified 3 cases in Scotland over 2 years (1992-94) providing an incidence level for Scotland of 0.3/100,000 population under 16 years of age.

This study did not survey non-accidental suffocation or poisoning, as did the BPSU (1996) study, although one case of induced apnoea and recurrent apnoeic attacks was noted by a Paediatrician in a very young infant from birth. Applying this to the U.S.A., Schreier (1997) predicted a minimum estimate of 200 new cases per year. (Amended figure).

The incidence level found here is lower than that of New Zealand which had a comparable size of under 16 year old population of 895,860, when a survey was conducted in 1999. Denny, Grant and Pinnock (2001) reported a combined incidence rate of non-accidental poisoning, non-accidental suffocation and Msbp of 2.0/100,000 children under 16 years of age. Unlike the BPSU (1996) survey, this study also surveyed (and included in the incidence level) *suspected* cases, which were not reported to child protection agencies, which had likewise been an inclusion criteria in the BPSU (1996) survey. Excluding these cases, the incidence level dropped to 1.2/100,000 children under 16 years of age.

The *suspected* cases of Msbp found in this study have not been factored into the calculation of the incidence level here, due to an important methodological difference. Paediatricians were not asked in this survey to categorise the degree of

parental fabrication of illness nor were they asked to quantify morbidity in the child victims. Here, this is provided in a qualitative analysis derived from interviews with the Paediatricians about parental behaviour, the core aspects of the abuse, case management and current outcomes for the victim(s). Child abuse, by its very nature, will never submit entirely to the rigors of scientific enquiry.

Age on Presentation and length of Time to the Conclusion of Msbp

The research literature has historically indicated that younger, particularly pre-verbal children are victimised more often than older children (Rosenberg 1987, Sheridan 2003) where there might be later collusion as the child accommodates to the view of herself or himself as ill or incapacitated in some way or cannot risk defying the mother for fear of loss (Libow 1995). By dint of their age and capabilities, younger children are more susceptible to a range of parental abusive behaviours, which they may not be able to relate or demonstrate (in play, for example). Likewise, are chronically sick, disabled children vulnerable (Eminson and Postlethwaite 2000. Precey 2002) where there is extensive handling, by parents, beyond early years, or medicating associated with a pre-existing condition or its ramifications: to provide a few examples, the use of feeding tubes, catheterisation, or the management of epileptic seizures in complex learning difficulties so as to require the administering of Diazepam, rectally.

Sheridan's (2003) recent literature review of 415 children has reported an average age of 48.6 months at diagnosis. Diagnosis was made in her sample in 31.6% of cases before 19 months of age and 51.7% before 24 months. Nearly all of the cases were diagnosed before 6 years of age. Sheridan (2003) has also reported an average time of 21.8 months between onset of symptoms and diagnosis.

In this study, the children with a conclusion of Msbp, including those 4 excluded from the calculation of the incidence level, were young. Only one of the 8 was much older, being 9 on presentation, albeit he had been frequently presented since 9 months of age. The remainder (7) were 5 or under with 58% under one year old. This concurs with the findings in the literature as to the vulnerability of young

children, particularly less than 5 years of age. This was also confirmed among the *suspected* cases of Msbp. Of those, for whom ages were available, only one child was older at first presentation at age 7. Of the remainder (13 children) 81% were below 5 years and 62.5% were below 3 years of age. Information about length of time between first presentation and the conclusion of Msbp is not available in the study for many of the cases. This represents a methodological problem. Although Paediatricians were being interviewed in all but 2 cases over the telephone, for fairly long periods of time – (in excess of 1 hour in most cases) – it was often difficult to press them on the length of time to diagnosis. This was understandably difficult given the time scale of the survey span and problems in retrospective recall, even although the Paediatricians were referring to case-notes, during the interviews.

Paediatricians were perhaps also understandably reluctant to quantify time-scale since this might reflect badly on them or their colleagues. Many of these cases provided *stark* reminders of the need to factor in the possibility of Msbp, as part of the differential diagnosis, in cases where treatment or diagnosis is proving problematic. This is widely recognised in texts, providing practical professional support to professionals (see Eminson and Postlethwaite 2000, Parnell and Day, 1998).

What is remarkable, in this study, is the number of children who had continuing and regular contact with the notifying Paediatrician, even into later childhood. There is on-going involvement in 2 of the confirmed cases of Msbp in children aged 5 and over and 1 continued until recently, into adulthood (1). The status of child (7) is not known, currently. If there is good understanding of the future risk which induced apnoea represents, child (3) (and siblings) should be monitored long term (Eminson and Postlethwaite, 2000, Pearce and Bools 2000). Child (6) continues to be monitored.

On the whole, the children represented in the *suspected* Msbp group had experienced the most prolonged periods of contact with medical services. As noted above, this group were, generally, presented young (81% less than 5 years of age). Thirteen of the children, for whom information is currently available, have on-going involvement with medical services. At least 7 of these cases involve older children

at age 10 and upwards, 2 were aged 15 and 12. One case (11) is now presenting with factitious epilepsy to adult services.

Most forms of fabricated or exaggerated illnesses are likely to fall away as the child resists or contradicts the mother's portrayal of illness signs and symptoms. However, collusion was suspected in one case (14), in which a girl may have bruised her own mouth with a bottle, to simulate signs of swelling and allergic reaction.

Induced apnoea and non-accidental poisoning are less common with age, in spite of case (8) noted here, where Msbp was confirmed, at the point when the child suffered a stroke due to hypernatraemia. She had endured years of fabricated illness until maternal reports of poor eating, over a prolonged period of time, provided a gastrostomy tube and the subsequent escalation of her abuse, since the child no longer had to accept the salt, by mouth.

The Evidence for Collusion and Active Induction

Cases of collusion in older children are thought to stem primarily from over-enmeshed parent-child relationships and a failure of differentiation between mother and child – a failure of separation. This has been described above (Green 2000). Problematic attachment and disturbance in the mother-child relationship sums up this process as well as accounting for a lack of empathy, sub-optimal maternal-child bonding and care-giver behaviours (Jones and Newbold 2001).

The work of Judith Libow (2002) provides insight into the mechanisms of collusion and beyond to active illness induction and self-harm. Libow (2002) suggests that young people, who go on to actively falsify illness in themselves, may have *learned about* illness falsification from a parent. This group of what Libow (2002) refers to as '*blended cases*' either collude directly or passively (Sanders 1995). Their level of awareness has been articulated on a continuum from accepting their parent's story of illness to partial awareness among some, who cooperate in a wish to preserve the relationship with the parent, to active involvement and collusion.

The evidence provided by these cases, illustrates the mechanisms by which children, themselves, go on to be active somatisers (McGuire and Feldman 1989) which can

go on to become a multigenerational disorder transmitted through the family system (Libow, 2002). *Blended* cases are medically complex, since it is difficult to determine where fabrication and collusion begin and end (Libow, 2002). This is exacerbated in children, with pre-existing conditions.

It is argued that none of the literature completely accounts for the processes by which a child moves from victim to active participant. Libow (2002) offers an explanation, by which the child moves from the passive role of victim to centre stage, thereby gaining a sense of control and establishing autonomy from the abusing parent. She suggests this as *one* pathway towards full-blown factitious disorder (Munchausen Syndrome), which demonstrates a link between adult MS and Msbp.

Libow's (2002) review of child/adolescent Msbp identified 42 cases in the literature (mean age 13.9 years) with a female to gender balance similar to the 3:1 ratio of episodic factitious disorders found by Taylor and Hyler (1993) in adults. These cases are distinctly rare in the literature. If early childhood experience of Msbp victimisation leads to active somatisation in adolescence and beyond, this might be better explained by the psychological adjustments accruing to the effects of sustained abuse in childhood. Children *accommodate* to abuse and fear of consequences (threats) or the loss of a parent (often, also a threat) prevents disclosure. Children as victims may go on to enter adolescence and adulthood with low self-worth, emotionally and psychologically damaged, often locating themselves within other abusive relationships and occasionally becoming abusers, themselves: hence the literature widely describes cycles of abuse. (Parton and Wattam 1999). It also recognises that there are not always identifiable consequences (Woodward and Fortune 1999) and that factors associated with age at onset, frequency and duration and severity, may intervene to mediate the effects.

The psychological adjustments required of an Msbp child-victim are likely to be of accommodating to *somatisation* and illness as a way of life. Initially, this may have been to preserve an enmeshed maternal relationship (Libow 2000, Green 2000) but subsequently, as a means of gaining attention, of filling a gap in their experience of care and nurturing, as avoidance (school attendance, physical activity etc.) or because no other life has been known and the child has learned to externalise

emotional distress or need through what is essentially a form of self-harming behaviour, via a distorted interaction with medical services.

Baildam and Eminson (2002) suggest that the child is ill-equipped to withstand the emotional pressure, emanating from a mother, to be ill. It is also difficult to intervene in such circumstances to extricate an adolescent victim from an enmeshed relationship with the mother. This threatens to upset the psychological equilibrium of the child, who may resist separation (Baildam and Eminson 2000).

Co-morbidity in Siblings

This was demonstrated in this research and is described above. There were 4 families, in which siblings of the index child were abused. In one family, 3 girls were abused from infancy, 2 being confirmed cases of Msbp. In 3 families one or more siblings of the index child was abused and in one family where Msbp was suspected (case 2), this was also the confirmed conclusion in her two female siblings.

The most notable example of multiple examples of abuse within one family is provided by cases 10-13 inclusive. In this family, abuse began early in each child and went on to provide several layers of short-term and long-term risk associated with: the experience of neglect and early deprivation, indirect and direct harm from physical abuse and, in one case, possible sexual abuse as well as accidental drug ingestion, factitious presentations to doctors, enforced invalidism, possibly to obtain benefits and somatisation behaviours as a way of life. The emergence of behavioural concerns in one of the children (case 12) provides some information about outcomes in terms of psychological sequelae which might hint at problematic family management and parenting style, which might be assumed to be chaotic and abusive of its members.

The study of co-morbidity associated with *Fabricated Illness* carried out by Bools, Neale and Meadow (1992) demonstrated that 11% of the siblings of 56 child victims of Msbp were dead and 39% had themselves been victimised in this way, by their mothers. This was later confirmed by Davis et al (1998), who found subsequent recurrence of abuse among 10% of siblings in a mixed group of cases. Occasionally,

the deaths of siblings or victimisation may only emerge *after* retrospective reviews of sibling case notes including SIDS (Southall et al 1997).

Outcomes

In the follow-up to the 1996 BPSU study, Davis et al (1998) found that 40% of the original children remained with their parents and a quarter were subjected to further maltreatment. A third remained on the child protection register. The re-abuse rate of children not involving direct physical harm was 17%. In 50% of families with a suffocated child and 40% with non-accidental poisoning, there was a high likelihood of further abuse.

With the exception of one young person now supported through community parenting, following her mother's death when the child was 14 years old (case 1) and one child, for which there is scant information available (case 7), the remaining 4 children, with confirmed Msbp abuse, resided with their natural parent at the time of notification. The child, who was suffocated (case 3) was removed and returned, eventually, after 6 months to its mother. The child of the mother who was an asylum seeker was put on the Child Protection Register. All of the children within the *suspected* group remained within their natural families at the time of notification, with the exception of one child (case 7), who was eventually freed for adoption. It is not known if the older children in this group still reside with their families or have moved out.

There were significant consequences for the children in the confirmed cases reflecting the serious nature of the abuse. The most obvious and serious outcome was for child (8) who suffered a stroke. Child (1) continues to require input from social services to cope in the community and is described as experiencing a problematic young adulthood. One child (7) was received into care. One child was not presented beyond 2 years of age and 4 others are reported as well, as far as is known.

The group of children in the *suspected* abuse category were, on the whole, older when notified and most had experienced years of prolonged, sustained abuse associated with over presentation, often with a range of problems and symptoms.

Some of this has already been discussed above as collusion and active illness induction. Other features of Msbp abuse in terms of its sequelae relate to the interruption to normal childhood (Taylor 1979, 1992) of school non-attendance and poor attainment with some children entering special education (cases 10, 12).

Of the *suspected* cases for which information is available (12), only one child (case 15) is noted as making good progress in school. Five children were reported with significant behavioural problems, one to the extent of meriting specialist support provision. It would be difficult to determine whether the reported behavioural difficulties relate to problematic parenting style or to the sustained abuse from over-presentations as ill or due to resentment of being *constructed* as being ill. To a great extent, it might be somewhat redundant – if ever possible – to tease this out. Two children were described as resentful of their 'disability' label (cases 5 and 10). The child (10) with a pre-existing condition (Spina Bifida) went on to manifest severe behavioural difficulties albeit it is again difficult to determine how much of this related, specifically, to the unnecessary brain surgery, to which he was subjected. Factitious seizures were reported in 9 children, 8 of whom subsequently received unnecessary anti-convulsant medication. One of this group (11) is now presenting with factitious epilepsy to adult services.

Involvement of Child Protection Services and Police

Social services were involved in each of the *confirmed* cases of Msbp and continue to provide support to cases 1 and 8 into young adulthood. The police were involved in 6 of the cases. The mother of child (8) was subsequently prosecuted and imprisoned. From the information available, social services were involved either directly on a statutory basis or in consultation with Paediatricians in 13 of the 16 *suspected* cases. The police had been involved periodically with the family of cases (10-13) inclusive. An anonymous call in respect of child (12) prompted a child protection investigation. This child's sibling (11) was placed on the Child Protection Register at age 3 years as was his sibling (10) following the ingestion of tablets. Both children were admitted together to hospital as a consequence.

The *Spectrum of Harm* Experienced by Children

Those cases, in which illness, signs or symptoms are fabricated or induced as in proto-typical Msbp (Eminson and Postlethwaite (2000) by mothers, who are '*active inducers*' (Schreier and Libow 1993), are likely to be less common events than encountered in *the spectrum of harm*, brought about directly or indirectly by mothers, who exaggerate and over-present children medically and provide false symptomatology histories. This group has been broadly described as '*doctor-shoppers*' (or addicts) and '*help-seekers*' (Schreier and Libow 1993).

The complications of any form of illness falsification for children can be serious, as the cases above demonstrate. The *deliberate* exaggeration of signs and symptoms, as opposed to the form of linguistic embellishment referred to by Morley (1995) is a potentially harmful behaviour. A mother may not set out actively to harm a child but this may be the end result through unnecessary examinations and investigative procedures, as well as providing long periods, occasionally years of involvement with medical services, *a psychological script* of illness and, in some cases a mantle of invalidism. Psychological disturbance, evidenced by the severe behavioural difficulties noted in several of the *suspected* cases, might represent resistance and attempts to 'break away'.

In the writers own case experience, a child was presented from aged 10 by his mother with factitious autism. Against advice, he was placed in a specialist provision at aged 12, following 7 years in mainstream schooling. In later adolescence, he developed a range of psychological anxiety spectrum difficulties, manifesting in *diagnosed* Obsessive Compulsive Disorder, stress related Depression and severe behavioural difficulties. As a 16 year old young man, remaining at home, he became truculent and difficult to manage and eventually, regularly assaulted his mother.

While it is tempting to lay the subsequent deterioration of this boy wholly in the lap of the factitious autism, there were clearly factors in the wider family functioning, which under-pinned events and which led to his presentation at aged 10. The questions which Yudkin (1961) suggested doctors should ask when presented with

vague symptoms: *what is the matter with the patient*? and *Why now*? are relevant here. Yudkin (1961) confirmed simple respiratory infections in '*six children with coughs*' but also that the agenda behind each consultation was different.

In the case of Tim (pseudonym), his mother's motivation may have been for attention and it is possible that she derived a sense of power, control and, therefore, achievement in manipulating professionals. There was evidence that she was fully aware of what she was doing. When the community Paediatrician did not confirm her description of her second child as having special needs, stemming from a range of reported difficulties, including being doubly incontinent and having mobility problems, the child went on to enter primary school normally. Her mother never referred to her again as having health problems. The third child in the family has significant learning difficulties, which provides the current battle-zone with professionals.

There is evidence in *this* study and elsewhere in the literature (Schreier 1996, Ayoub et al 2000) that children may be presented factitiously *around* professional systems, either as a starting point, as in the family described above, or, eventually concurrently.

School staff may be among the first to note inconsistencies and incongruities in the picture presented, by parents, or in the child's behaviour, when separated. Staff working with child (8) (salt ingestion) were able to provide temporal associations between their positive reports to the child's mother about her food intake, in school, and immediate absences due to reported ill health. In the case of *suspected* illness falsification in child (10) school staff were able to contradict her mother's portrayal of the child as having poor mobility to the extent of requiring a wheel-chair to get to and from school. Left alone, this child took part in all school activities, including dancing.

On the whole, this study identified two broad groups of children, which fell inevitably into *confirmed* and *suspected* cases based on the conclusions and information provided by the notifying Paediatricians. In keeping with Baildam and Eminson's (2000) experience, those cases, in which children presented acutely, in a

series of single events, provided undisputed examples of illness induction or fabrication. In cases, which provide examples of doctor-shopping and gross manipulation and exaggeration, it becomes more difficult to confirm and substantiate abuse once the concern begins to dawn.

Deciding whether or not parental behaviour in seeking health care for a child *is* abusive and , therefore, where *the critical threshold* of risk and harm lies, is made the more difficult to determine when parental behaviour shades into abuse by the health care system (Baildam and Eminson 2000).

In children where there are pre-existing conditions, this process is exacerbated and even more problematic becoming a diagnostic conundrum. In these situations, doctors may resort to generating new hypotheses and diagnoses to understand anomalous diagnoses.

In an early paper, Meadow (1985) cautioned *against* the rare diagnosis noting that in most cases Msbp will provide a more common explanation of the clinical phenomenology. In this study, child (8) presented from her early years with mild developmental ataxia and poor feeding. This was diagnosed as ataxia telangiectasia, a rare terminal condition (Office of Rare Diseases/National Institute of Health Website (2007)). Three cases per million population are diagnosed each year, in the United Kingdom. This may have diverted attention away from considering other explanations to account for the child's symptoms.

Postlethwaite, Baildam and Eminson (2000) have highlighted the vulnerability of paediatric *sub-specialisms* to being misled. They suggest that '*specialists*' tend to be removed from cases of child abuse and child protection work, most cases dealt with and filtered out at the level of the community Paediatrician. Likewise, their reliance on the case history, rather than clinical findings and the pressure to come up with a diagnosis – even a rare one- adds to their professional susceptibility.

Lacey et al (1993) reviewed all cases of later confirmed Msbp referred to a surgical faculty over 5 years. Of the 10 children referred, 9 underwent endoscopy (upper/lower gastrointestinal tract) and/or bronchoscopy. Six out of the 10 children

were subjected to further surgery (Nissen fundoplication (5), gastrostomy (3) and simple cases of Broviac catheter placement, bronchial lavage, muscle biopsy, relief of a small bowel obstruction, tonsillectomy and myringotomy. One child had 12 operations (revisions) subsequent to having a central venous catheter placed for feeding. Lacey et al (1993) concluded that it is important that paediatric surgeons have an awareness of Msbp since children will often come their way for evaluation. They state that '*....paediatric surgeons may become the tools, by which more serious illnesses are actually inflicted on the child*'. (Lacey et al 1993 in Eminson and Postlethwaite 2000 p131).

All systems and specialisms have been targeted by carers, attempting to make factitious presentations. Those which present opportunistically but in some cases, acutely in outpatients, are most commonly associated with non-specific childhood conditions presenting as: poisoning, vomiting, seizures, diahorrea, apnoea, fevers, unconsciousness, lethargy, dehydration and haematemesis.

Children in this study were presented with a range of conditions. Seizures were reported *alone* or in combination with other conditions in 11 cases. This is a common finding in the literature and is a condition difficult to both disprove or corroborate. Newton (2000) has commented on the difficulties inherent in the use of the label Epilepsy, which he describes as a pantechnican term. He notes that the diagnosis is difficult to make and to shift.

The frequency of factitious Epilepsy reported in the literature would suggest that mothers, intent on providing false medical histories, may catch on to the problems inherent in the corroboration of seizures. Among the *confirmed* cases one mother provided a friend, perhaps an unwitting witness. In these cases, the harm to the child emanates *directly* from unnecessary medication and, *indirectly*, in terms of distorted beliefs about health status.

The severest outcomes were to be found in this group of child-victims ranging from having to be weaned off anti-convulsant drugs, continued, perhaps colluded presentation into adolescence, and on into active induction, in one case.

The Presentation of Children in Msbp

Eminson and Postlethwaite (2000) argue that the previously held *bargain* between parent and doctors, by which a child is presented to them for health care, based on the history of signs and symptoms, provided by the parent, no longer holds true. They cite changes in the doctor-patient relationship accruing to patient power in terms of demanding procedures, treatments and second opinions and changes in paediatric practice: increased access to wards on a 24 hour basis, utilising parents as carers on wards with access to charts, samples etc. and a less than optimal emphasis on *good enough* clinical practice in history-taking and corroboration, are significant factors, which can engender and maintain Msbp child abuse.

General Practitioners will also have experience of repetitive over-presentation of children. Their referral route will typically be to refer to specialist Paediatricians for an opinion. They have a particular role in attempting to contain demands for referrals.

Most Msbp cases present in out-patients, some acutely with a swift assessment if the presentation appears to be life-threatening. In this context, doctors will meet a whole range of parenting capacity, both in terms of intellectual ability and in terms of their ability to form relationships within a health care system as well as their motivation to be there (Postlethwaite et al 2000). As already noted, it is important to understand the implications in the question '*why now*?' (Yudkin 1961) and the *meaning* of the presentation of the child as well as the *meaning* of the child, within the family context (Reder and Duncan 1999). Understanding cycles of family functioning and issues in attachment provide ways in to understanding the mechanisms and processes, which under-pin abuse. Msbp is an example both in origin and outcome. (Libow 2003).

Postlethwaite et al (2000) have drawn attention to the need to understand parental belief systems, often media or neighbourhood driven and parental concern focused on *within-child* factors or functioning. Labels such as Attention Deficit Hyperactivity Disorder (ADHD), embedded in the lore of food allergies and

additives divert from issues around problematic parenting and *within family* functioning and dynamics. In this context, the symptomatic child mirrors the family's problems to the world but it is only in the context of therapeutic work that this may become explicit.

Although ADHD presents commonly to child psychologists more often *not* in the context of Msbp, it is nonetheless parental misrepresentation or misunderstanding, accruing to a belief system (*he eats blue smarties and drinks too much Irn Bru*) or to beliefs about the child (*he has been difficult from birth, there's something mentally wrong with him)* which labels the child, and often also provides medication (Ritalin) if the parents persist hard enough or seek referral to a '*tame*' Paediatrician. The cynical *medicalisation* of children to secure benefits or better housing, likewise may appeal to those with restricted or limited social and intellectual resources, who recognise opportunities to get more and more – of anything – out of the system (Postlethwaite et al 2000). Diagnoses of developmental disorders (autism spectrum or behavioural difficulties) based on uncorroborated parental reporting represents questionable practice. Once the diagnosis is made, particularly in the early years of a child's life, it becomes difficult to modify or revise in later childhood or adolescence.

Maternal Functioning and The Issue of Motivation

For ethical reasons, no information was sought about the psychological status of the carers or their own illness history. For the majority of mothers there is little or no information. However, from the few details, which emerged during the unfolding of the medical history of specific cases, there was evidence of long-standing patterns of family somatisation behaviour, in one family over generations, maternal depression and alcohol and drug use. One family, in particular, (suspected cases 10-13 inclusive) demonstrated the worst combinations of neglect, physical (and possibly sexual) harm and somatisation behaviour, across generations. This family also provided an important case demonstrating how collusion in childhood can develop into active involvement and distorted illness behaviour and falsification, in later life.

It was not possible to draw any inferences about maternal *motivation* from the notified cases nor were any specific mental health conditions noted by the Paediatricians which they had been made aware of, apart from depression. Although abnormal illness behaviour and somatisation behaviour have to be weighed in as risk factors for Msbp (Meadow 1995, 2000, Eminson and Jureidini 2003) these factors alone do not account for Msbp and are never probative of child abuse. The distorted reality and thinking associated with personality disorders and schizophrenia may have a qualitative effect on the content of an individual's parenting skills and interaction with a child but alone are unlikely to account for deliberate planned attacks on children or the prolonged periods, often years of over-presentation to doctors, characteristic of Msbp.

In the Bools, Neale and Meadow (1994) study of 47 mothers, who had perpetrated Msbp abuse, 72% were judged to have somatising disorders and '*the majority*' a personality disorder with widespread disturbance to both social and personality functioning. This group of women were also known to have fabricated illness, in themselves, and to have experienced emotionally impoverished backgrounds, often with abuse. In later life, other forms of self-harm, substance and alcohol abuse were noted in their psychiatric histories. These findings were confirmed in later case series (Gray and Bentovim 1996, Southall et al 1997).

There is, however, no evidence that this group of women are different from others nor does one factor or constellation of factors contribute directly to Msbp and acts of child abuse. Nor is there uniformity or evidence of a natural history of progression from verbal fabrications and exaggeration to active induction. (Eminson and Postlethwaite 2000). There might be some evidence, which indicates that mothers, who actively harm children may be more *damaged* in their relationship with their child than those, who do not bring about direct or potentially life-threatening harm as in non-accidental suffocation or poisoning. While the behaviour of women, who attempt to interrupt their pregnancies may be a *form of attention-seeking* akin to wishing *to assume the sick role* (DSM IV T-R 2000), it also signals assaults on the child as being indicative of early pre-natal attachment difficulties.

Most examples of *pre-natal Msbp* are at the individual case-reporting level: Condon (1987) was the first to describe the battered foetus syndrome, which continued post-natally. Goss and McDougall (1992) provided the first report relating self-induced pre-term delivery to subsequent Msbp abuse. However, Jureidini's (1993) case-review evidence, drew attention to cases, in which obstetric complications and Msbp were linked, either as a causative factor or as an outcome.

This remains a rare event but, as in cases of Msbp child abuse, may not be recognised and, therefore, under-reported. Postlethwaite et al (2000). Higher than average obstetric complications such as ante-partum haemorrhage or emergency Caesarean Section in mothers perpetrating Msbp, in live children, has been identified (Jureidini 1993, 2003). Previous peri-natal bereavement, *still births* and SIDS, which occur commonly in families, where there is Msbp abuse, has likewise been linked with grief and maternal depression, which has also been linked with children who are difficult to manage (Walker, Garber, Green 1993). Depressed, grieving mothers may, in innocence, over-present children or exaggerate symptoms in a state of anxiety or in fear of the further loss of a child. These parents, who are essentially seeking reassurance, benefit from counselling and support by medical staff.

Not enough is known about these particular pathways and whether they lead to abuse, although there is recognition of the need to understand them (Eminson and Jureidini 2003). Mothers, with few exceptions, will not actively harm children following traumatic pregnancies or deliveries: however, some will *but may have done so, anyway*. There are problems inherent in retrospective analyses, which look to identify markers or particular risk factors. This has proven to be a *holy grail*: there are no risk or profile predictors of Msbp or any other forms of child abuse. Those embedded in models of maternal psychopathology and motivation (Bools et al 1994, 2000 Schreier) inadequately account for the behaviour, are too restrictive and are not a pre-requisite to evidence child abuse (Rosenberg 2003).

The evidence for maternal psychopathology: personality disorder (Bools et al 1994, Samuels et al 1992) and of parental psychopathology, in the few cases involving fathers as perpetrators (Schreier and Libow 1993) are not probative nor do they demonstrate causation. The only exceptions may be those cases, in which children are over-presented to doctors by a carer, whose delusional disorder, gives rise to the belief that the child is ill (Warner and Hathaway 1984).

Kelly and Loader (1997) have likewise described a range of *motivations*, which offer a broader redefinition of Msbp. They describe *direct* harm through fabrication resulting in unnecessary procedures or induction and the production of physical signs or symptoms and *indirect* harm through impaired and interrupted educational and social development and giving a child erroneous information and feedback about his/her health. They cite 7 '*scenarios*' which provide no inference about motivation or maternal psychopathology. These recognise: (1) parental anxiety and the seeking of multiple opinions to allay concern. Exaggeration reflecting fears of genuine illness; (2) to divert doctors from other forms of child abuse e.g. physical harm or failure to thrive; (3) a belief of genuine illness in a child also linked to depression or delusional disorders or, hypochondriasis by proxy; (4) to be antagonistic e.g. in custody battles; (5) to protect the child from abuse elsewhere by another perpetrator, hospitalisation providing sanctuary; (6) enmeshment/mothering to death; (7) financial motivation in the shape of disability benefits and allowances. Kelly and Loader (1997) underline the importance of understanding relationship influences in women, who perpetrate Msbp and the availability of family supports. They note that female perpetrators commonly perceive themselves as socially isolated, without support and under stress.

The earliest case notifications (Meadow 1977) and case series Samuels and Southall (1992), Gray and Bentovim (1996), Southall et al (1997) were concerned with the most serious manifestations of primarily induced illness by mothers in their children, which led to speculation as to motivation (akin as it was to Munchausen Syndrome), which, in turn, slipped into enquiries as to maternal psychopathology (Bools, Neale and Meadow 1994). Increased case experience, recognition of a *spectrum of harm*

and a range of parental behaviour in seeking health care for children, militate against there being a distinct motivation based on attention seeking behaviours in health care settings alone.

The literature does not support the need to account for maternal motivation in order to establish that child abuse has taken place, (Rosenberg 2003, Eminson and Jureidini 2003. RCPCH Guidance on FII 2002). The trend of constructing female aberrant or problematic behaviour as mental illness (and pursuing this through research) has its origins in 18th and 19th century concepts of female insanity, which is where this thesis began. It is agreed here and throughout that Msbp is child abuse and *not* an illness and that there is more to be gained from understanding the mechanisms and processes leading to abuse than trying to account for its origins purely in terms, which stress maternal disfunction. Arguments centred on maternal psychopathology are reminiscent of notions of causal determinism, which holds that behaviour can be predicted as it can be in nature (or, organic illness) Thomas and Bracken (2004).

Satisfaction With The Involvement of Other Services

As part of the survey, Paediatricians were invited to reflect and comment on their experience of working with other services *in Msbp cases* and their satisfaction with their involvement. They were also asked to pin-point key pieces of advice, which they would share with colleagues, which would help them in the future handling of Msbp cases.

The notified cases provided very varied approaches to contact with other child protection services: from no involvement, which occurred in those cases requiring minimum intervention with *mild suspicion* and which were well managed, by Paediatricians, without the formal intervention of social services, through the spectrum of harm to cases informally discussed with social services, as concerning, to those where regular consultation was necessary, and on to the severest cases, in which formal child protection procedures had been initiated. The need to comment

professionally about parental behaviour increased incrementally with the harm to the child and increasing levels of medical suspicion.

Child Protection Procedures

Child protection procedures were initiated primarily in the group of *confirmed* cases of Msbp, although one child (7) in the *suspected group*, was removed from the parental home and freed for adoption. It is unclear, however, if the years of presentations for factitious epilepsy *alone* produced this result. Several children were on and off the child protection register across their life-spans.

Children (10-13 inclusive), who represented the most *at risk* group to emerge from the survey, had the heaviest involvement of child protection services and were also described as being well known to the police. Various members of the family had been on the child protection register at some point in their lives. Two of the children were put on the child protection register after being admitted to hospital for ingestion of prescribed drugs.

Child protection services were more likely to be initiated when there was *demonstrable* evidence of physical harm or of serious and persistent fabrication, hence social services were involved in every *confirmed* case and police were involved in three *confirmed* cases (3, 6 and 8), where there was *actual* or a significant risk of *future* harm or death and periodically in suspected cases (10-13 inclusive). In the *suspected* cases child protection services (and other children's support services) involvement was associated with a range of complex risk requiring assessment and support.

Two of the Paediatricians reporting *confirmed* cases (1, 8) described feeling 'frustrated' by the lack of direction and decision-making by social services, which prolonged the abuse of both children but particularly of child (8). However, differences in medical opinion as to the aetiology of child (8's) condition, which was thought to be exceptionally rare, may have clouded the medical picture, thereby curtailing the ability of social services to act within the child protection legislation.

That child (8) had a pre-existing condition, complicated the picture making clear-cut decisions as to the harm, which the child may have been experiencing, difficult to recognise in the first instance and difficult to quantify.

One Paediatrician, who notified case (3) noted feeling satisfied with social services involvement both in the removal and return of the baby, who had been subjected to induced apnoea, by its mother. The Paediatrician, who notified confirmed cases (4, 5) and suspected case (2) noted issues in respect of different views of harm and especially of risk and how they should be managed. This was also noted in cases (5, 6) in siblings living in foster-care. In spite of significant medical concerns about the children, there was insufficient evidence for Social Services to remove them to another foster-placement.

A lack of Msbp case experience, among all professionals involved, including those medically qualified, was noted as compounding difficulties in child protection work in this area. One Paediatrician who had noted 2 *suspected* cases (3, 4) described her own lack of confidence and fear of missing a diagnosis so that she had referred to a specialist Paediatrician for an opinion. Postlethwaite et al (2000) have identified this problem as a barrier to identifying Msbp abuse. They suggest that in some cases, making a diagnosis becomes more important than appraising presentations and the child's health in a broader sense. This extends to chasing the rare diagnosis as exemplified in case (8). However, the importance of consulting paediatric colleagues, particularly those with responsibility for child protection work is recommended where there is doubt or a lack of confidence. Consultation with colleagues is emphasised in texts, which look at the day-to-day, practical management of Msbp cases (Eminson and Postlethwaite 2000) as well as being emphasised in professional Guidance (RCPCH 2002).

The RCPCH (2002) Guidance provides diagrammatic representation of emerging professional concerns and responsibilities within child protection guidelines, matched to medical evidence of harm and risk to the child with a range of possible subsequent outcomes for the child and family. This is reproduced below:

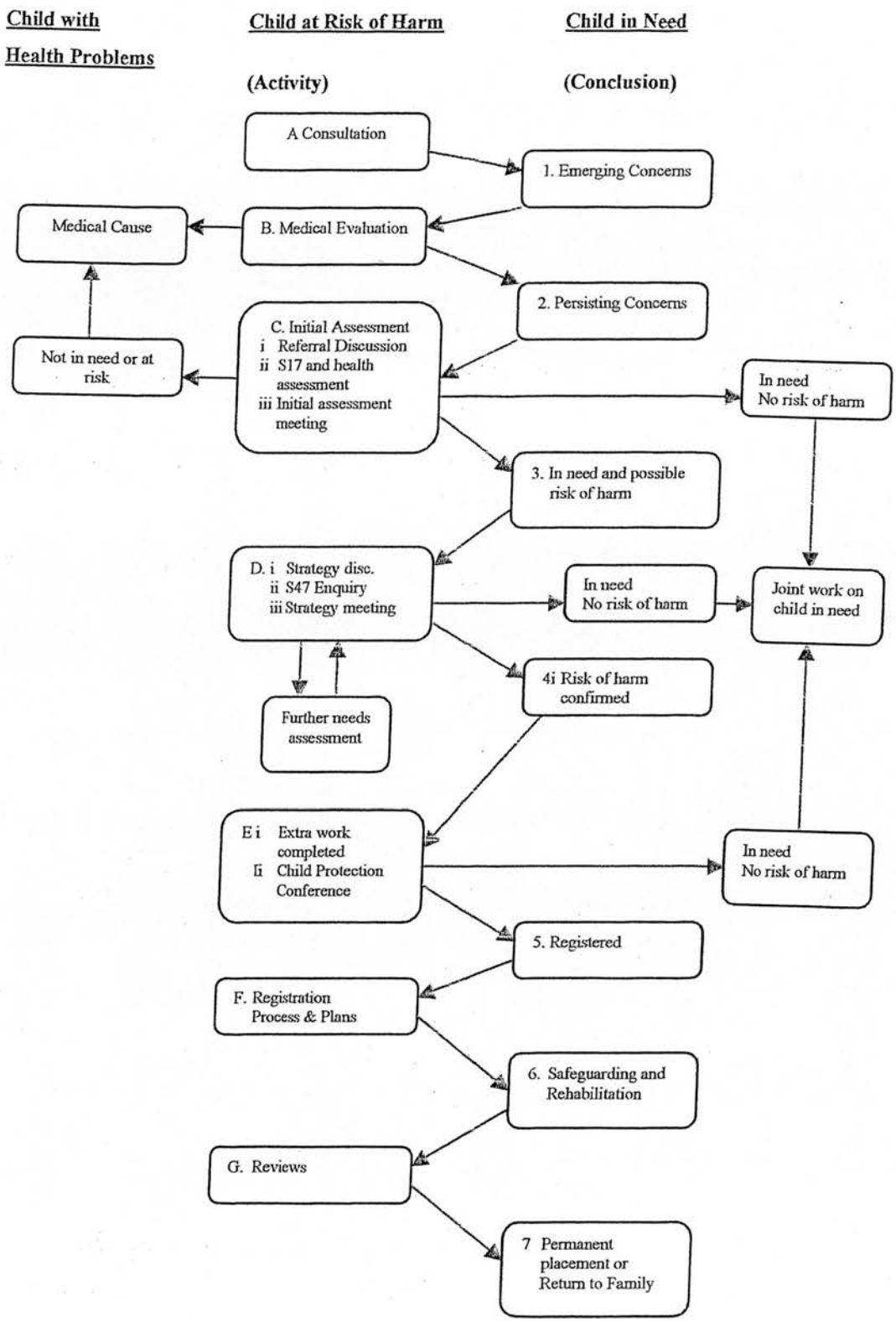


Figure 3 Royal College of Paediatrics and Child Health (2002)

(Reproduced by kind permission)

Providing Evidence of Harm and Acting On Concerns

As noted throughout, it is often difficult to evidence harm to a child, particularly to satisfy the threshold criterion of *significant* even when it is physical in origin. This becomes even more difficult when parental behaviour shades into the exaggeration of signs and symptoms and becomes iatrogenic (Eminson and Postlethwaite 2000), as noted above.

Evidencing psychological and emotional harm from being over-presented or misrepresented as ill is more difficult by being ill defined. Consequences, such as short-term physical and psychological distress, which can go on to represent longer term physical and emotional harm, accruing to distorted self-perception and a distorted relationship with the carer are noted (Baildam and Eminson 2000).

Glaser et al (2001) in a commissioned study looking at emotional abuse and neglect, in children, argued that emotional abuse is distinct from other forms because it refers to *a relationship* rather than an event, which need not involve physical abuse. However, physical abuse also fractures and distorts relationships so that it would be difficult to determine when one form of abuse ends and another begins. Glaser et al (2001) make the distinction between the psychological *characteristics* of ill-treatment from their psychological effects upon the child.

The BPSU Epidemiological Study carried out in Britain by McClure et al (1996), described in detail above, drew several main conclusions about the reporting of Msbp cases by Paediatricians. These are worth re-considering, here, since although this study would support their conclusion that Paediatricians must be '*virtually certain*' (p60 1996) about the evidence for Msbp, before approaching social services to seek a case conference, it does not support their conclusion that Paediatricians, in areas with low reported incidence levels are failing, '*to either recognise or notify cases*'.

There is a subtle shift in interpretation, which recognises the likelihood of procedural differences between Local Authority Social Services Departments in agreeing to convene child protection case conferences and the difficulty, which is recognised among experienced Paediatricians, of having sufficient evidence to demonstrate that

the critical threshold of harm has been reached so as to merit the need to consider compulsory intervention in a family. This has been discussed above.

In this study, as in the BPSU (1996) study, child protection services, including police, acted to safeguard children, in cases, in which children had been presented with induced apnoea, non-accidental suffocation and the fabrication of signs and symptoms, which carry a high tariff for present and future risk and harm. In cases, in which risk is less obvious or certain, intervention is, perhaps necessarily, more measured, although carrying risk accruing to delay. (confirmed case 8).

In this study, Paediatricians differentiated between the *monitoring* of children in families by social services departments, registration on the child protection register and compulsory measures of care, ensuing from formal child protection procedures. As noted above, there were concerns about not having sufficient evidence to approach social services departments for either a formal case discussion or a child protection case conference (CPCC), particularly in cases where evidence was at the concern and suspicion *only* level or worries about the emotional abuse and harm of a child.

The Baspcan Study (Glaser et al 2001) also concluded that children tended to be older when *registered*, as part of the child protection process, as suffering emotional abuse. This, they explained, as '*a genuine delay in recognising emotional abuse*' rather than '*a finding of last resort*' (p45 2001): child indicators of psychological/emotional abuse constituting a *wide non-specific spectrum* of *impairment of children's development* (p45 2001) rendering specificity difficult.

Paediatricians, in this study, had clearly given much thought and evaluated the long-term implications, for some cases at least, of going down the child protection route and the possible deleterious effects on future work with the family and child/ren.

Baildam and Eminson (2000) suggest that decisions *for* and *against* monitoring of families, as opposed to confrontation, must take account of and weigh up the potential risks in either strategy. A confronted parent may quickly adopt '*a polarised anti-medical stance*', or bolt - only to present the child elsewhere.

The mother of child (7), which was a confirmed case, traversed the country, doctor-shopping, using false-names and tracking medical staff so as to avoid detection. Her ruse was discovered when she was recognised registering her family, using false names, with a G.P. practice, where she had previously been a patient!

Avoiding Further Harm to The Child

Green (2000) has cautioned against the use of direct confrontation in cases involving adolescent victims, which carries a particular connotation of psychological risk, associated with extricating the child from an enmeshed relationship with the parent, particularly when the parent's belief system about illness and of being ill has been pervasively integrated into the child's intellectual functioning and way of life. In these circumstances, where there has been a blurring of the psychological boundaries between parent and child (Green 2000), providing the child with a script, which offers a different reality needs careful work and therapeutic in-put.

The literature does not often pose the question, never mind provide the answer as to how children can be helped to understand years of abuse. In cases, in which children have integrated their parent's belief systems about illness and about *their* illness, it is difficult to disentangle the child.

Libow's (1995, 2000) work, which has provided information about active illness induction among adolescents and about the long-term effects of Msbp among adult survivors, signifies the importance of recognising and dealing appropriately with psychologically enmeshed Msbp cases.

Jones et al (2000) have noted the need, in therapy work, to help children understand their past and that decisions perhaps to separate them from their families, were taken in order to protect their future psychological health. This '*script*' is not suitable for younger children but it is one, which at some point in their lives they may need to hear. This might be one mechanism by which to halt inter-generational abuse.

Weighing up Risk of Remaining with The Perpetrator

In this study, children were more likely to be removed from their mother's care when there was evidence of *direct harm*. Among the confirmed cases, case (3) was presented with induced apnoea and case (6) with fabricated signs of blood on a baby bib. Whenever there was a lesser degree of certainty, children were less likely to be removed from the source of the abuse. In case (1) the child was removed to foster-care at age 12 years, having been presented from age 5 years. In case (8) the child was presented from age 5, her abuse escalating over the 3 years prior to an incapacitating stroke, at which point her mother was arrested.

In the suspected group, apart from one child (7), those, for whom information was available, remained within the care of their mothers at the time of notification. All of the mothers in the confirmed group of cases had denied abuse. Case (6) provides a particularly worrying example of '*magic*' being cited to explain fabricated signs of illness. Depending on the context, in which the explanation was provided, given the ethnicity of the mother, this case draws attention to the need to recognise and understand the belief systems of parents and to work within their intellectual capacity. There may be heightened risk to children in these contexts.

Recognising Risk and Future Harm

It is difficult to quantify the harm to children of Msbp and the spectrum of harmful parental behaviours. Rosenberg (1987) was convinced that Msbp brought harm to all affected children. This study has demonstrated different levels of response to harm depending on the severity of the child's presentation and the risk of further abuse. It has also demonstrated that it may be difficult to persuade other professions of existing or potential harm in the absence of physical evidence such as that provided by active fabrication and induction.

Repetitive over-presentation for health care and exaggeration of signs and symptoms are difficult to substantiate within the legal framework and definition of Significant Harm (Children (Scotland) Act 1995). As noted above, the track-record in recognising and registering emotional abuse or maltreatment is poor and provides

likely under-estimates of this form of abuse, particularly when occurring not with physical abuse (Glaser et al 2001).

In this study, Paediatricians described poor management of risk and, therefore, potential harm in 3 *confirmed* cases (1, 6 and 8). The Paediatrician notifying case (3) noted that the case had been handled well and the child had been successfully returned to her mother. The Paediatrician notifying case (6) expressed concern that the child was returned to her mother and removed from the child protection register without complete agreement of all concerned in the case.

Paediatric Practice in Identifying and Managing Msbp Cases

A number of Paediatricians, particularly those reporting *confirmed* cases of Msbp, described what they saw as good clinical practice in managing Msbp cases. On the whole, in both the *confirmed* and *suspected* cases, Paediatricians emphasised the need for good communication between professionals both within and outwith medicine. The importance of the family G.P., in managing requests for referrals to specialists, was highlighted here and is noted in the literature. (Pearce and Bools 2000). Their case-notes also provide a source of family medical history, which can potentially yield valuable corroborative information, particularly in providing a chronology of referrals and consultations.

The Paediatrician notifying 2 *confirmed* cases of Msbp emphasised the value of taking time to scrutinise *all* of the medical case-notes specifically to track the chronology of events and presentations of a child or siblings in a family.

The Paediatrician notifying case (1) attempted, when possible, to check the gynaecological and obstetric history of mothers presenting at a specialist developmental assessment centre, in cases with a high degree of suspicion of illness falsification.

Factitious obstetric complications was first recognised and described by Pickford, Buchanan and McLaughlan (1988) and self-induced pre-term delivery, relating specifically to Msbp abuse (of the foetus) by Goss and McDougall (1992). (Both papers are cited in Eminson and Postlethwaite 2000). The work of Jureidini (1993) has strengthened the link between factitious illness, in pregnancy, and later on-set Msbp abuse and indicates that the early pathways to abuse may lie in early mother-child problematic attachment. Eminson and Jureidini (2003) have recently highlighted this as an important and very relevant research area. Understanding this type of factitious disorder may add to the protection of current and future children (Bluglass 2002).

On the whole, Paediatricians valued open-ness with parents rather than confrontation and where possible, management through monitoring, particularly in cases where there was insufficient evidence to proceed to the level of a child protection investigation. In serious, life-threatening cases, presenting acutely, this was not possible but for the bulk of Msbp cases, at the *suspicious* but *difficult to substantiate* level, monitoring and managing the family's need to seek health care for a child, best describes the clinical practice here. This was described as being less likely to antagonise the family, thereby '*losing*' the child to potentially greater risk of abuse, elsewhere.

Maintaining case control (Pearce and Bools 2000), thereby preserving continuity of case responsibility and involvement is an important mechanism in professional practice, for managing and, therefore, minimising the likelihood of further harm to a child or children, in a family.

Postlethwaite et al (2000) have emphasised the importance of applying good basic clinical skills to solving medical anomalies and problems. Borrowing Oski's (1994) analogy and recommendations, they list the use of clinical algorithms (flow-charts), pattern recognition as used in the '*intuitive recognition*' of illness and importantly hypothesis generation as to the origins and nature of the patient's problem as alternatives to '*sampling the universe*' (Oski 1994), by ordering exhaustive testing

and procedures. Oski (1994) also drew attention to the need to resist parents demands for tests even if this was for their reassurance and to consider, above all, the potential harm to the child.

The community-based Paediatrician notifying case (8) drew attention to the importance of directly following-up reported illnesses by arranging to visit the family or by seeking clarification of the mother's story from other medical professionals, who might have been involved.

Issues in Respect of Future Risk to Children

The professional literature is extremely cautious about maintaining children in families, following Msbp abuse. The early research by Bools et al (1993) drew attention to re-abuse through illness falsification following confrontation. As outlined more fully above, of 23 children out of an original group of 54 child-victims of Msbp, in their study, who were still living with their mother, 10 were subjected to further fabricated abuse and concerns were raised in respect of a further 8. Those who had not remained with their mothers demonstrated long-term morbidity in terms of psychological and emotional abuse associated with the original period of abuse.

There is some dubiety as to whether Msbp escalates from mild to severe forms (Parnell and Day 1998) although there is some suggestion that it might, in serial Msbp (Alexander et al 1990). Eminson and Postlethwaite (2000) take the view that there is scant evidence to substantiate progression from mild to severe falsification. Evidence of co-morbidity in siblings (Bools et al 1992) and in this study, of multiple layers of physical and possible sexual abuse, coinciding with neglect, maltreatment and illness falsification, indicate that not only do different types of abuse and neglect coincide but different types of illness falsification coincide, perhaps even in the same child. In the family of 4 children (cases 10-13 inclusive) described here, while epilepsy provided the main focus for presentation, they were also presented to Rheumatologists and Accident and Emergency Departments with an assortment of disorders and accidents.

Various authors in this field have provided contextual frameworks for monitoring children at home or to re-establish the child, within the family once abuse in uncovered. These concentrate primarily on serious manifestations of Msbp abuse. The level of support and in-put required by a family may well be on a sliding scale, based on the type and severity of the abuse. The assessed risk to the child should guide the level and type of intervention required to meet the child's need for protection and the reduction of risk.

Jones et al (2000) are clear, however, that since fabrication of illness may be embedded in wider family and parental breakdown and maltreatment, re-unification should only be considered in exceptional circumstances or where there are many positive features – as would also be the case in suffocation and poisoning. In this study, 2 children (case 3: induced suffocation, case 6: fabrication of haematemesis) were returned to their mothers within the first year of life, within months of being removed.

Meadow (1995) identified risk factors pointing to reunification as contra-indicated. He drew attention to:

- abuse by suffocation or poisoning
- of a child less than 5 years of age
- a lack of understanding by the mother of what is happening
- available family and social support as well as understanding
- a mother herself with Munchausen Syndrome
- alcohol/substance abuse
- fabrication post confrontation

Schreier and Libow (1993) also advise caution when there is existing illness in a child, thereby providing opportunities and a context for further abuse. In terms of the parent's state of mind, these authors consider it important that they have crossed over into a level of insight into their behaviour and have developed alternative coping strategies for the resolution of their own psychological needs as well as being able to demonstrate improved parenting skills and capacity. Given the

psychodynamic orientation of their work (Schreier, in particular), Schreier and Libow (1993) have recommended long-term psychotherapy, with two consulting psychotherapists – to counteract transference. Legal protection of the child so as to restrict '*doctor-shopping*' and to curtail the family's movements is recommended by Pearce and Bools (2000).

In extreme circumstances, Kinscherff and Famularo (1991) suggest immediate termination of parental rights. They suggest the future potential harm to a child is too great and potentially lethal given the lack of any known and effective psychiatric intervention with perpetrators to change their behaviour, in combination with evidence that children continue to be abused post discovery and during treatment and the difficulties in providing long-term protection through social services. Determining what constitutes *a long enough term of protection* is fairly arbitrarily drawn at the stage when children are less vulnerable and available to their parents. This is unlikely to protect well-disguised collusion as a by-product of over-enmeshed parent child behaviour or abuse into adulthood as demonstrated in the work of Libow (1995, 2002) and Sanders (1995).

The strength of this view was also arrived at by McGuire et al (1989), who concluded that even when the risk of physical harm was removed, there was continuing psychological harm to children remaining in families. This recognises problematic parenting and the child's experience of the emotional content, which has pervasive affects on child development, irrespective of the presence of Msbp abuse. Their allusion to attachment theory offers explanations embedded in the child's experience of the parent, the parent's availability for parenting and the emotional content of the relationship between the parent and child.

The work of Ney et al (1994) has made a link between early onset verbal abuse and emotional neglect, with a marked increase in the frequency of child abuse and severity. Not unsurprisingly, this study concluded that neglect is an early precursor to many forms of abuse.

The RCPCH Guidance (2002) deals with this issue by providing a structure for evaluating professional concerns about a child through the application of the 3 domains of the Assessment Framework embedded in sub-section 5:13 of *Working Together To Safeguard Children*[4] *(1999)*. In question form:

- what are the needs of the child?
- are the parents able to respond appropriately to the child's needs? Is the child being adequately safeguarded from significant harm, and are the parents able to promote the child's health and development?
- is action required to safeguard and promote the child's welfare?

The guidance draws attention to trigger-points, which relate to unresolved diagnostic problems, which might signal Msbp in difficult to resolve cases.

Demonstrating risk, by reference to research, might be particularly pertinent in a comparatively rare form of child abuse, which few professionals will have encountered. It may be particularly useful to offer training to social services personnel, who have case responsibility. Reaching consensus and a common understanding of Msbp per se, of maternal behaviour and the management of denial are crucial (Neale et al 1991, Schreier and Libow 1993) and has been noted as a fundamental pre-requisite to re-unification, with the perpetrator, following discovery or where there is more widespread parenting breakdown or maltreatment (Jones et al 2000).

Managing Denial

The literature has established fundamental prerequisites to reunification with the perpetrator following discovery, particularly in cases of induced apnoea and non-accidental poisoning or where there is more widespread parenting breakdown and maltreatment (Jones et al 2000). One of the most important risk considerations is whether there is acknowledgement of the abuse and cooperation with *treatment* and

[4] Working Together To Safeguard Children. Department of Health, Home Office, Department for Education and Children (1999). Supplementary Guidance for Safeguarding Children in Whom Illness is Fabricated or Induced (2002)

in-put from child protection agencies (Jones et al 2000). Managing and working with denial is, therefore, a cornerstone of intervention work.

All of the mothers in this study, in the confirmed cases, denied the abuse. It might be said that child (6) was returned to his mother without cognisance of potential future risk and against medical advice. Jones et al (2000) emphasise the need to collectively establish aspects of risk, which need to change (and whether the individual is capable of change) in order to achieve a *consensus* of views regarding the criteria for unification. Overcoming professional denial and lack of acceptance is recognised as the first hurdle in the identification of Msbp, contributing to under reporting (Eminson and Postlethwaite 2000). Faced with incongruent information about a mother, who appears well adjusted on a ward with good inter-personal skills with staff, nurses may find it difficult to challenge their own perceptions of a mother to come to see her as a perpetrator (Blake 1990). Szajnberg et al (1996) drew attention to the style of perpetrator interaction with professionals, which made it difficult for them to suspect (or accept) abuse (in Eminson and Postlethwaite 2000). Schreier and Libow (1993) make an important point about the possibility of over-identification with perpetrators to the extent of being '*taken in*' by them: hence, their stipulation that 2 therapists jointly engage in the therapy process with clients.

Although there may be little or no evidence substantiating mental illness or dysfunction in a perpetrator, Jones et al (2000) note the importance of a *psychiatric appraisal* not only of the mother, if she is the perpetrator but of the wider family's functioning. Assessments should aim to determine the level of acceptance of the abuse not only by the perpetrator herself but by the wider family, who will contribute to protecting the child. Denial is the norm (Bools, Neale and Meadow 1994) and hazardous, representing a contra-indication for reunification in severe cases of Msbp abuse (Davis et al 1998). Carers presenting with persistent denial are unlikely to cover sufficient ground within the timescale required to meet the child's needs (Jones et al 2000), which will have implications for decision-making as to whether the child can remain within the family. In this context, a father, able to protect and take responsibility for a child, while crucially recognising the potential risk, which the

mother may represent, can become an important factor in determining whether a child remains within a family (Jones et al 2000). Other family members can also work together to protect a child. Wider family acceptance of the perpetrators actions is particularly important, in cases where they are part of providing supervised access by the mother to the child. Not accepting the potential for future re-abuse and harm – particularly in illness induction or fabrication – can spell disaster for a child, particularly if left alone and unsupervised.

Neale et al (1991) drew attention to the risk associated with poor family supervision, in circumstances, in which the care-plan for the child is not adhered to or poorly adhered to, in spite of an initial willingness to do so. They suggest that this is perhaps inevitable given the circumstances and the tendency for awareness or alertness to risk to reduce over time or a lack of awareness that abuse can persist even during therapy, and beyond.

Involvement of Child Protection Services

Only a minority of cases of Msbp are reported to social services. Most are monitored and managed by health care services, within the community (Smith 2000). This is borne out by the findings here. Compulsory measure of care, to the extent of being removed from the mother's care happened in 4 of the 8 *confirmed* cases and in 1 of the *suspected* cases, associated with repetitive presentation of factitious epilepsy (child 7). Only this child was formally removed from the mother's care and was freed for adoption. In 2 of the 4 confirmed cases, reunification was not possible due to maternal death in one case (case 1) and incarceration in the other (case 8). Both babies (cases 3, 6) were returned home to the mother's care within their first year of life.

In cases where there has been life-threatening, serious illness induction or fabrication, multi-professional, inter-agency assessment is important to assess the current and on-going risk, which the mother, as perpetrator, presents to her child/ren and her capacity and more importantly psychological availability to recognise and change her behaviour (Jones et al 2000, Parnell and Day 1998).

There is wide recognition of the need for long-term monitoring of families where there has been Msbp abuse, and long-term psychiatric assessment of the mother to monitor relapse even following discovery (Meadow 1985, Bools et al 1992). Berg and Jones (1999) reported continuing depression, anxiety and exaggeration of illness in a group of perpetrator mothers, for themselves. Day (1998) reported generally poor therapeutic outcomes with perpetrators. She cites the role of resistance and non-compliance with therapy and the complications inherent in counter-transference between therapist and their more manipulative *clients*.

Schreier and Libow (1993), in recognition of this, recommended that two therapists co-work cases to avoid over-identification, in therapy, and the creation of dependence and over-reliance on forming relationships and bonds, within this context. Since perpetrators have described feelings of loss and abandonment, in early childhood, and a life-time seeking approval and recognition: it would be further damaging, affirming the belief system of the mother further, if this *perceived* bond were to be fractured or ended. (Schreier and Libow 1993).

As noted, throughout and cited above, reunification, where there has been a poor *treatment* outcome, in terms of continuing denial, poor or borderline recognition and acknowledgement, by the perpetrator (and family members) is contra-indicated, particularly in cases involving induction and serious fabrication of illness signs and symptoms. Mothers compelled by courts to attend an adult psychiatrist for assessment and '*treatment*' may also do so, reluctantly, with little cooperation or honesty.

In this study, there is some evidence of therapy offered to two mothers only, on a short-term basis. The Paediatrician notifying *confirmed* case (3) had case-note evidence of therapeutic in-put to the child's mother but had no evidence of outcomes or professional follow-up to the family involving his psychiatric colleagues.

The literature widely emphasises the need for well-coordinated case-management, by a core group of identified professionals, across all child protection agencies working

with shared understanding of Msbp, to an agreed care plan (Jones et al 2000). In *confirmed* case (6) the child was removed from the child protection register without the Paediatrician's agreement. Good practice holds that there should be consensus among all professions as to changes to the care plan or de-registration of the child as being '*at risk*' (Pearce and Bools (2000)). Reder and Lucey's (1995) articulation of this as *therapeutic assessment*, recognises its dual purpose as a means of assessing the child's safety if re-united with the perpetrator and whether there is sufficient evidence and positive signs to suggest good outcomes from therapy (Jones et al 2000).

Pre-requisite Assessment Tasks and Models for Intervention

A central task will be to determine whether the mother is capable of differentiating her own needs from that of her child for nurturing, love and care. Since most children affected by Msbp are young (Meadow 1982) and often pre-verbal (Libow 1995) assessment should take account of the developmental stage of the child and the tasks involved in mother-child bonding as well as empathy. This information becomes available through observation of mother-child interaction in clinical settings and will take account of how well the mother is able to respond to her child, for example, when it cries (Jones et al 2000) or seeks proximity. The quality of *reciprocity* between mother and child, even absent Msbp, has major implications both for the immediate and long-term welfare of the child, cognitively and psychologically. Assessments of parental competency and attachment to the child provide fundamental indications of the likelihood of change in the mother's behaviour towards the child and her ability to meet the child's developmental needs. As noted already, the tasks of assessment will vary with the developmental age and needs of the child and whether these can be met quickly enough. Feedback to a responsive mother can be therapeutic to the child (Jones et al 2000).

There is agreement in the literature that maintenance of the child's ecological environment, where there is lowered (evaluated) risk is important. A major barrier to this and contra-indications for reunification have been noted as maternal denial or partial acknowledgement. Both have been shown to persist (Libow 1995). In their

study of maternal psychopathology, Bools et al (1994) noted denial not only of the abuse itself but of other problems. This caused them to conclude that assessment and therapeutic work with perpetrators might be difficult, requiring long-term psychiatric assessment and support and cooperation. Parnell and Day (1998) suggest that by the time a mother comes to fabricate illness, she may have perfected the ability to suppress and deny her own behaviour.

Feldman (1994) suggests that teaching adaptive ways to deal with unresolved needs and issues might obviate the need to express feelings, without inflicting pain on (self) or dependent children. This approach is widely used in working with adolescent children, who self-harm. This more broadly reflects wider interpretations of Msbp, outwith models whose emphasis lies in individual maternal psychology. Although psychological difficulties are labelled, consistently, throughout the literature, these describe vague, ill-defined conditions such as Personality Disorder or Somatisation Disorder (Bools et al 1994) which do not adequately account for Msbp child abuse nor do they explain *why* a child is selected for abuse and how its mother can overlook the harm and suffering she is inflicting and being experienced by her child (Meadow 2002). Explanatory models, which take account of gender, family systems theory, theories of women's psychological development and child abuse (Parnell and Day 1998) are important adjuncts to individual features of functioning and temperament. These are recognised as forming the basis of treatment frameworks (Parnell and Day 1998).

Parnell and Day (1998) argue that women develop a sense of identity through caring for others, particularly their child/ren. Presenting a *sick* child validates this role further and provides recognition and attention to women, whose own early history may have been characterised by neglect, abuse and victimisation where being ill guaranteed attention and illness had currency both within and outwith the family. In this model, women who do not know *how* to be good mothers and whose own early attachments and problematic bonding has been poor so that they have reduced subsequent empathy for their own children, present as *'caricatures'* of mothers (Parnell and Day 1998), which medical services nonetheless validate while they fail

to recognise them as *'imposters'* (Schreier and Libow 1993). Further perspectives suggest that women are more vulnerable to using their own children to satisfy their needs (Parnell and Day 1998) as well as their own bodies to communicate distress and to gain a sense of control (Motz 2001).

The Focus of Therapy

A broader understanding of the likely mechanisms of Msbp provides a framework for assessment and likewise *a treatment framework*, the aim of which is to work towards acknowledgement, improved attachment and empathy (Parnell and Day. 1998). This has better outcomes for the child if the mother's behaviour is understood as an outcome of multiple layers of social and cultural influences on women played out within the family system rather than emerging from illness *by proxy* or, mental illness, although where there *is* illness, this can be irremediable (Taylor 2000). Taylor expresses this eloquently by posing a question about *'the individual reasons for the actions of those who hurt their children by misrepresenting their state of health'*. He goes on to suggest that we should look outside bioscience *as, by definition, the child is not ill or diseased* and into *the biography of those caught up in the fiction. The truth is discoverable only in terms of an account of the fibre of the lives of the participants* (Taylor 2000 page x).

Parnell and Day (1998) note the need to carry out individual therapy work with the mother based on approaches to therapy used with adult survivors of child abuse. This recognises a possible personal history of abuse and neglect, feelings of abandonment and victimisation as well as poor experience of attachment and sub-optimal bonding in what is the first significant relationship in life. Working in therapy towards improving a woman's capacity to parent a child, thereby meeting the child's needs, as opposed to her own, can emerge only with an understanding of what, in her own history, led her to abuse her own child.

Although understanding Msbp requires also an analysis of wider family functioning, the cooperation of families with therapy or family systems work can be difficult to achieve. In the writer's own experience, the drop-out rate is high, particularly when

it becomes too difficult to meet the tasks and, more importantly the psychological and emotional adjustments required to bring about change within a family system. It is easier to identify one of its members as *'the problem'* to be changed.

Psychologists will recognise parents insisting on an ADHD diagnosis for a child presented with behavioural difficulties, who find it difficult to accommodate a shift in emphasis *away* from within child factors, towards an examination of their parenting style and management, as well as towards factors in the psychological and emotional functioning of the family, which might under-pin and scaffold the child's behaviour.

Referring to the work by Manthei et al 1988, Day and Ojeda-Castro (1998) note that in dysfunctional families, children *'carry the burden of pathology'* (page 204 1998). In this respect, the literature draws attention to the benefits of individual therapeutic in-put to child victims of Msbp.

In this study, 2 of the confirmed cases (child 1, 8) sought continuing contact with the notifying Paediatricians. Child (8) contacted the specialist Paediatrician who had known her from childhood to meet to discuss what had happened to her. There was no indication from the notifying Paediatricians of therapy made available to the children post discovery.

Libow (1995) describes post-traumatic stress in adulthood and a persistent fear, among adult survivors of Msbp, of doctors and medical treatment. The little information, which exists, from adult survivors is available from Judith Libow's work (1995, 2000). Adults reported feelings of being unloved, insecure and reported later life problems with reality-testing, so accustomed had they become, in childhood, to deception and elaborated falsehoods about them. Children, who were older when the abuse was occurring, attempted to alert other adults to this, to no avail. *Believing* child abuse exists is the first major barricade to recognition and reporting no matter how the abuse manifests itself. It might, however, be *particularly* difficult for an adult to comprehend a child's story of being made ill, by

a parent even in today's world when there is heightened awareness of Msbp, albeit fairly well misunderstood as being essentially a maternal illness, rather than child abuse.

The aim of therapy with child-victims of Msbp abuse should, therefore, aim to redress imbalances in the child's life depending on the child's developmental stage and the developmental tasks, which require to be met. Therapeutic in-put to mothers can be, in turn, therapeutic for younger children (Jones et al 2000) with evolving understanding of the child's needs and the emergence of empathy.

Evidence of later active illness induction in themselves, the transmission of Msbp patterns of behaviour across generations in families (Parnell and Day 1998, Libow 2000) and the importance of intervening in the development of somatising behaviours, as a pathway to Msbp abuse (Emison and Jureidini 2003) signifies the importance of therapeutic intervention. Parnell and Day (1998) recommend from their own clinical practice, play therapy with younger children and individual therapy sessions with older children.

Children subjected to periods of being misrepresented as ill to the world and subjected to unnecessary medical presentations and procedures develop a distorted self-image of themselves and of their parenting experience. The tragic case of child (8), who was left very significantly disabled by her abuse, strongly underlines the need for victims, above all else, to understand what has happened to them and why. In this case, a number of factors are complicit including iatrogenic harm.

It is not known if intervention with victims interrupts or prevents the further development of maladaptive responses manifesting in abnormal illness behaviours in themselves or future children. This is an area requiring further research in terms of type of therapy required and efficacy. What is known about therapeutic intervention with mothers following discovery is not wholly positive. This is noted by Parnell and Day (1998) in their own clinical practice and elsewhere. They noted that the literature struggles to describe successful treatment cases. This is perhaps

predictable and inevitable given their complexity and the spectrum of factors underpinning the abuse which would require to change. The literature has remained unequivocal in its view that in serious cases of Msbp child abuse, children cannot remain in families where there is a poor treatment outcome (Jones et al 2000, Bools et al 1995, Schreier and Libow 1993, McGuire and Feldman 1989).

In summary, the literature stresses the importance of therapeutic in-put to carers and families (Jones et al 2000). This was demonstrated also in the work of Gray and Bentovim (1996). The literature is likewise unequivocal in its emphasis on the need for well coordinated and centralised multi-professional case-management of Msbp cases to further protect the child and to support professionals working in this difficult area of child abuse (Jones et al 2000). Jones et al (2000) emphasise the need for the assigning of clear professional roles in managing families, and of establishing agreed and understood aims and objectives in reducing future risk to the child. This should include the establishment of a core team with a lead clinician monitoring the child's health and referrals. In this context, the child's General Practitioner is central to managing the risk to the child of unnecessary referrals.

Reaching a consensus as to what has to change is an important first step in identifying elements of risk to be targeted, in the work, both with the perpetrator and the family. The paediatric and psychiatric contribution to the assessment is in substantiating the medical evidence of harm to the child as well as the likelihood of recurring future harm to the child (and siblings) given what is known about re-occurrence of abuse (Bools et al 1992, Davis et al 1998).

CHAPTER 6

Comments on The Research

The research demonstrated an incidence level of Msbp of 0.4 per 100,000 population, in children under 16 in Scotland, which was only marginally higher than the incidence level found in the BPSU (1996) study by 0.1 per 100,000 population under 16, carried out over a decade, previously. This is unlikely to be significant given the small numbers of cases and the low base rate (Mart 2002). This and other research confirms *Msbp* as a rare form of abuse at least at the severest end of the *spectrum of harm.* Recent research carried out in Australia by Tait et al (2004) estimated an annual incidence of between 15.2 and 24.5 cases. However, as will be discussed below, incidence rates are also affected by the use and understanding of the terminology. Cases of actual or induced harm, as in non-accidental poisoning or suffocation, implied in the terminology 'Fabricated or Induced Illness in Children (F.I.I.) (RCPCH Guidance 2002) being less common than harm brought about through less direct mechanisms of illness falsification and misrepresentation of children to doctors.

By the very nature of child abuse, the reported incidence levels of *Msbp* are going to be inevitably lower than the true level may be. This may seem to be a bold statement but the covert nature of some forms of child abuse, particularly sexual and problems in definition, for example, in describing some forms of physical activities as abuse or quantifying psychological and emotional maltreatment, constitute *real* difficulties, in practice. While some of these characteristics will spill into research into Msbp, specific difficulties accrue here, which relate to case ascertainment and associated problems in the formulation of Msbp and, therefore, to the use and understanding of terminology.

Mart (2002) has provided a critical appraisal of Msbp, predominantly on the basis of statistical grounds and has drawn attention to what he sees as a problem of *reification* in the early formulation of Msbp. His approach is very much in step with that of

Allison and Roberts (1998) whose thesis contributed the view that Munchausen Syndrome and Munchausen Syndrome by Proxy emerged naturally from historical *slants* on the relationship between disease, women and madness.

To reiterate some of the points, which they make to demonstrate the point about reification: they argued that '*the Munchausen litany*' grew out of case notifications by doctors, following Asher's (1951) paper, without addressing Asher's (1951) original formulation of Munchausen Syndrome and whether it was a valid one. This and other incidence studies (BPSU 1996, Denny et al 2001 N.Z.) have partly engaged in the same process by inviting case notifications matched to a medical label (Msbp or Mbps, non-accidental poisoning or suffocation in combination). However, the Msbp label carries particular connotations, which may act to contextualise referrals. There are several ways of looking at this: cases exist as genuine examples of Msbp or as examples of parental abnormal illness behaviour with non-specific motivation but the maternal behaviours match a *profile*.

The problems inherent in this approach have been described above and are widely represented in the literature (Morley 1995, Fisher and Mitchell 1995, Mart 2002). This operationalises different effects in that doctors receiving the first survey relating to this research, may have recognised cases and parental behaviour in the working definition provided but may not have recognised or ever considered them as providing examples of Msbp and, therefore, did not notify them. A lack of recognition may contribute to under-reporting (Eminson and Postlethwaite 2000) but equally does a lack of clarity as to what is meant by the terminology as well as the definitional position in respect of to whom it refers.

The '*no-case returns*' to this survey provided some examples of doctors who clearly did not expect to encounter cases of fabricated illness in children, irrespective of terminology or level of understanding. An example of this came from a G. P.

Likewise, one very senior specialist Paediatrician referred to a child's mother as '*having this condition*' (which had caused her to bring about severe physical harm to her child). It is difficult to surmise what this *condition* might be.

It is believed that significant information about what are sometimes viewed as *lesser* cases of Msbp, emerged from the research, which although lacking the immediacy of potentially life-threatening presentations of children, as in induced or even fabricated illness, nonetheless carried the potential for short and longer-term outcomes and harm.

It is believed also that the research cast light on issues in respect of professional practice. However, in retrospect, more information about the spectrum of cases might have become available had doctors been asked to notify cases, in which concerns about parental behaviour, in seeking health care for a child, was at a level to formally alert child protection services *absent* any terminological references to Msbp or F.I.I. but employing the terminology of Significant Harm.

There is some indication in research carried out by Watson, Eminson and Coupe (1999), that this might have been a more useful approach. Based on the assumption that there is no agreement on where the critical threshold of harm lies, Watson et al (1999) asked doctors, in a particular health district to nominate cases, where there was an excessive seeking of health care by parents in respect of a child under 16 years of age, to the extent that they considered whether Significant Harm to the child was occurring. They identified 58 children in 42 families, which was equivalent to 89 children per 100,000 population, under 16 years of age, experiencing parental abnormal illness behaviour, over a 2 year period. Watson et al (1999) concluded that while it was likely that the more serious cases had come to light, their research had confirmed – as here – that there is a broader spectrum of '*disturbed and distorted consultation behaviour by parents for children*' than thought. (In Eminson and Postlethwaite 2000 p.32).

Eminson and Postlethwaite's (2000) later conclusion about this study draws on the analogy of an *ice-berg*, in which the tip represents the severest end of the spectrum, with a large unseen area of parental discrepant or abnormal health seeking behaviours, for children. They also draw attention to the need for clear operational definitions of the concepts involved, which is the argument here.

Although this research is only able to comment on a return by one G. P. who noted '*I am unlikely to see cases*' and it is, therefore, not wise to extrapolate any significance from this, Watson et al (1999) found that G. Ps did not identify cases, which they had judged crossed the threshold of harm, did not refer them to social services but chose instead to refer them to Paediatricians when in doubt (Eminson and Postlethwaite 2000) or, perhaps under pressure form a parent to do so. This is of concern since G.Ps are important first line case managers, who effectively have the power to control specialist referrals to Paediatricians and who, later, are pivotal in the management of cases, post-discovery (Baildam and Eminson 2000). Professional understanding of this form of child abuse and of carers, who perpetrate the abuse, particularly among any *core* group of professionals involved in monitoring, which should include the child's G. P., is emphasised as crucial in the later protection of child-victims (Pearce and Bools 2000).

Defining Significant Harm

Apart from the more immediately serious cases resulting in the removal of children from their family's custody, the bulk of cases, described in this research, were monitored by Paediatricians, in some examples with Social Services involvement. Demonstrating *actual* harm or a *risk* of harm, as described in the legislation (Children (Scotland) Act 1995) is problematic in this context. In the seeking of a child protection order to protect a child, the following represents the definition, which Social Services Departments work to, in Scotland. This principle is of *the balance of probability* and not *beyond reasonable doubt*. Although, as Mayer et al (2000) have pointed out, this can be more difficult to evidence and substantiate:

(a) there are reasonable grounds to believe that a child –

(i) is being so treated (or neglected) that he is suffering significant harm or:

(ii) will suffer harm if he is not removed to and kept in a place of safety, or if he does not remain in the place where he is then being accommodated (whether or not he is resident there);

and

(b) an order under this section is necessary to protect that child from such harm (or such further harm), he may make an order under this section (to be known as a 'child protection order').

(GREEN'S ANNOTATED ACTS. CHILDREN (SCOTLAND) ACT 1995).
NORRIE 1995.

It will be evident that many manifestations of falsified illness in children would never satisfy these criteria, which describe circumstances, in which children are in need of immediate care. The RCPCH Guidance (2002) has addressed the problem of evidencing serious examples of Msbp abuse in criminal cases and has recommended that legal proceedings be preceded by an independent review of the evidence by a panel of experienced doctors. This removes the need for courts to rely wholly on adversarial opinions (p13).

Mayer et al (2000) have also noted that courts tend to require very cogent evidence of child abuse before acting to protect the child. Demonstrating the wider facets of a likely distorted and harmful relationship between a perpetrator and child, provides a framework for contextualising wider aspects of the child's experience of maltreatment, however it manifests. Mayer et al (2000) have outlined key

assessment domains or what they refer to as a '*welfare checklist*' to guide professional thinking about whether or not the threshold into significant harm has been crossed – arbitrary though this is in some cases:

1. The ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding).
2. Physical, emotional and educational needs.
3. The likely effect of any change of circumstances.
4. Age, sex, background and any characteristics which the court considers relevant.
5. Any harm which she/he has suffered or is at risk of suffering.
6. How capable each of the parents, and any other relevant person, in relation to whom the court considers the question to be relevant, is of meeting the child's needs.
7. The range of powers available to the court under the Act in the proceedings in question.

(Mayer et al 2000 in Eminson and Postlethwaite 2000 p262).

The Problem of Gender and Mental Illness as Frameworks for Understanding Msbp

This thesis began by tracing the antecedents of Munchausen Syndrome by Proxy (Msbp) within historical themes of constructing incongruent or problematic behaviour, particularly among women, as mentally ill. This draws heavily on perspectives such as that provided by Showalter (1985), whose work has examined the role of gender in the construction of madness as a female malady and provided a feminist critique of psychiatry, as well as the analysis of the social and cultural determinants of mental illness and the emergence of professional psychiatry, by Allison and Roberts (1998). Fisher's (2000) perspective on the processes, by which medical narratives shape doctors perceptions of patients is apposite, here. Women, who harm their children by falsely presenting them to doctors are seen as '*imposters*' as providing examples of a *perversion of mothering* (Schreier and Libow 1993,

Meadow 2002) or as having fallen short of some innate biological standard implicit in being a mother. Motz (2001) has drawn attention to difficulties in accepting female violence so that gender-based assumptions have historically led to explanations embedded in psychological functioning.

Influential publications such as '*The Battered Child Syndrome*' (Kempe et al 1962) confirmed the importance of understanding maternal functioning (Lutzker and Bigelow 2002).

Currently, however, although more comprehensive theories of child abuse and maltreatment are available, which might cast light on Msbp child abuse and which supplant psychodynamic explanations, (Lutzker and Bigelow 2002) the issue of maternal functioning and *drive* continues to provide a back-drop to Msbp even more so is understanding the motivation to present children to medical services. So, for example, although fairly exceptional in the literature, the comment on the importance of transference and counter transference in Munchausen Syndrome by Proxy by Dr. Pompili and colleagues (2003) in the form of a '*letter to the Editor*' of a prestigious journal makes this point:

> *'Troubled relationships in childhood may tempt the mother to look for a second chance for 'ideal love' in adulthood. Paediatricians and other physicians may be idealised and considered the caring person whom they have always wanted to meet. No doubt, these women compulsively seek the father's love that they have never obtained. It is little wonder that these mothers look like ideal parents, trying to appear perfect in the care of their children'. (lines 15-20 2003).*

and later, in the same letter, (replicated with a slight grammatical error).

> *'Psychiatrists and physicians should always evaluate the role of transference and counter-transference in the treatment of these patients. The former usually begin a therapeutic challenge, analysing the very root of their behaviour, often going back all the way to childhood. At some points of the therapy only the analysis of mutual feelings may be therapeutic, a work which requires, great commitment and efforts on both parts. (lines 40-44 2003).*

The association of a form of child abuse (Msbp) with factitious disorders in adults was always a theoretical position as was the psychodynamic formulation implicit in '*to assume the sick role*' (by proxy). This provides a reductionist interpretation of Msbp and provides what Lutzker (2002) refers to as a defect model. Although this remains a corner-stone of the psychiatric diagnosis of Msbp the current professional literature is now concerned less with this than it is in establishing Msbp as child abuse and evidencing abuse *outwith* medical models of disorder (Rosenberg, 2003).

The literature does not support there being a specific profile of risk, motivation or psychological presentation (Eminson and Postlethwaite 2000, Kelly and Loader 1997, Morely 1995, Fisher and Mitchell 1995), although there is some evidence of abnormal somatisation behaviours in perpetrators (Meadow 1995, 2002) of personality disorder (Bools et al 1994) and depression (Southall et al 1997). These, and maternal behavioural characteristics associated with Msbp, are non-specific (Morley 1995, Mart 2002). Although classified as psychiatric disorders (DSM IV T-R 2000, ICD 10) somatoform disorders may be personality characteristics (Eminson and Postlethwaite 2000, Bass and Murphy 1995) and not a discreet psychiatric illness leading on to falsifying illness in one's own children.

Generally speaking, women who *do* present with mental *illness* and thought disturbance of the severest kind are not over-represented among women, who harm or bring about harm to their children. The study by Southall et al (1997) of 39 cases referred for investigation of ALTE did not find high levels of psychiatric illness among women, later confirmed as abusing their children. Difficulties inherent in distinguishing and isolating a psychiatric profile and the personality dynamics of mothers, who falsify illness in children, relate to problems in the original formulation of MS and, subsequently, Msbp.

Mart (2002) draws attention to problems in drawing conclusions from small samples and argues that a lack of co-variant analysis, which would be required to confirm clinical impressions about the meaning of maternal behaviour is lacking. He concludes that this has led to illusory correlations and assumptions about the behaviour and motivation of mothers, which cannot be substantiated in something, which is such a rare event. He describes the need to compare women falsely presenting children within medical contexts, with the behaviour of women with chronically sick children, who regularly attend for health care.

In similar vein, Wood (1996 in Mart 2002) has cautioned that rare disorders are likely to be over-diagnosed unless the diagnostic criteria are well-defined, measured exactly and, most importantly *rare in the absence of the disorder*. Exact *measurement* is likely to be unattainable, given that we are dealing with human nature, which cannot be measured Mart (2002) but these arguments highlight the dangers implicit in psychological and behavioural profiling.

Recent diagnostic criteria, such as those proposed by Rosenberg (2003) do not now recognise any pre-requisite need, for the identification of Msbp, to consider factors relating to perpetrator intent, motivation or individual psychopathology.

In Britain, this approach is evident in the RCPCH Guidance (2002) supported by a recommended change to nomenclature devoid of references to Munchausen Syndrome and, by inference, implied maternal psychopathology. The terminology Fabricated or Induced Illness (F.I.I.) by carers (2002), however, spot-lights only the severest manifestations of this form of child abuse. Although the Guidance recognises models such as that proposed by Eminson and Postlethwaite (1992, 2000), identifying *a spectrum* of harmful parental behaviour, this is not reflected in the new terminology.

Applying the terminology - F.I.I. - to some of the cases described here would be a misnomer, since most had symptoms neither induced nor fabricated: yet there is

evidence that children were nonetheless harmed, by periods of over-presentation to doctors with exaggerated conditions. This lies at the nub of what is a definitional conundrum. However, with a reduced emphasis on the connotations of maternal psychopathology, it becomes easier to employ other frameworks for understanding this manifestation of child abuse and to account for maternal behaviour. These are more likely to engender, in turn, improved inter-agency work when there is shared understanding of the nature of the abuse and how to approach and work with carers, who harm children directly or indirectly through presentations to doctors. There is value in looking at other theoretical models of child abuse and maltreatment, which are not centred on psychiatric problems in the perpetrator.

The early case-series (Bools et al 1994) set out to identify individual psychiatric risk factors among women identified as Msbp perpetrators but, in keeping with later research (Southall et al 1997) have provided evidence of carers whose own childhoods and adolescence were characterised by emotional and physical maltreatment and neglect, leading to behavioural and psychological 'malfunctioning', including self-harm, substance and alcohol abuse, as well as somatisation behaviours, in themselves. Their lives, as adults, were typically chaotic. Southall et al (1997) concluded that those with somatisation disorders were often the most desperate and attention seeking.

This 'framework' characteristically draws attention to *a problem individual* – i.e. a mother. By contrast, developmental and ecological models such as that proposed by Jones and Ramchandani (1999) cite individual characteristics and experience within the wider social and cultural context of the family, as providing a causal explanatory model of child abuse. This is demonstrated below. (Figure 4)

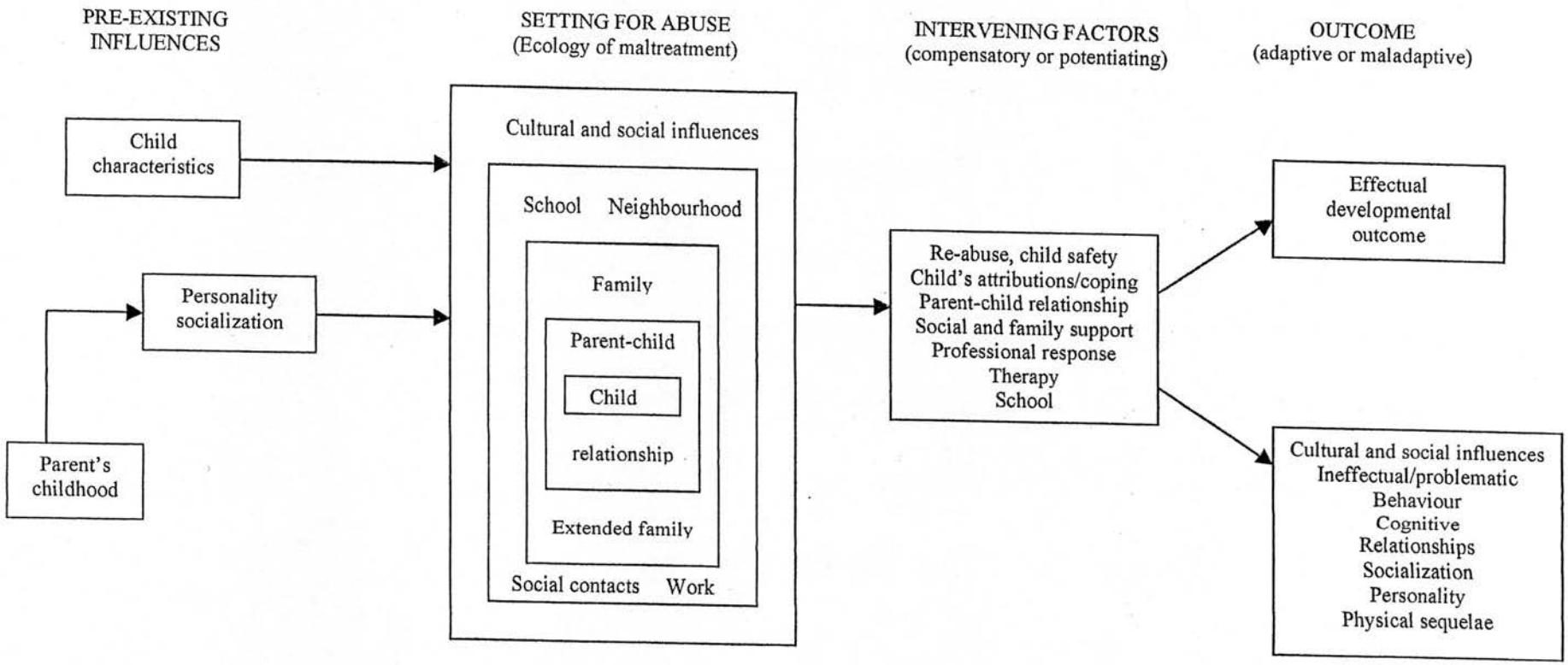


Figure 4 A developmental and ecological perspective on child maltreatment. (Reproduced from Jones, D.P.H. and Ramchandani, P. (1999)

Lutzker and Bigelow (2002) also suggest that understanding what they refer to as defect and deficiency models of child abuse does not differentiate individuals or families, who when faced with the same set of circumstances, *do not* go on to harm their children. They argue against the disruption assumption as a mitigating factor in child abuse and outline the benefits in models and therapeutic approaches to parent work, which take into account parent-based cognitive disturbance and behavioural skills deficits, as well as problems in impulse control, stress management and those associated with poor social functioning. Approaches such as this might conceivably also take account of problematic attachment in the aetiology of non-nurturing, abusive interaction patterns between mother and child.

The work of Southall et al (1997) also drew attention to temperamental factors, among the mothers in their sample, influencing the relationship with their children. They noted observable problematic attachment and lack of empathy in their style of interaction and responses to their children. Their research, as here, has drawn attention to the need to recognise multiple causal factors and pathways in the origins of their abuse, understood in interactional/relational terms as providing a context for the expression of individual temperamental factors.

The importance of understanding the wider context or ecological aspects of abuse are likewise recognised by writers, who conceptualise Msbp within a broader spectrum of likely familial maltreatment and sub-optimal parenting (Mayer et al 2000). This recognises the importance of *evaluating* the emotional content of the child's experience of the parent, in terms of meeting the child's holistic developmental needs.

This can be therapeutic for the child (Jones et al 2000), particularly post-intervention, and can be observable, informing questions as to the capacity for change and, therefore, decisions about the future potential risk to the child, of remaining with the natural carer. Therapeutic assessment and in-put within a rubric, which recognises different levels of parenting capacity, which may or may not emanate from individual psychological problems or frank mental illness can be effective in mediating the effects of child abuse. This approach aims to identify what needs to change to make a woman a safer mother and – importantly – one able to recognise her child's needs as

opposed to her own and, who has the capacity to meet these needs, given appropriate levels of support and cooperation.

Explanatory models derived from theoretical perspectives on maternal psychopathology do not yield information sufficient to protect a child nor do they adequately guide subsequent strategies for intervention in families where abuse has occurred.

Munchausen Syndrome by Proxy: A Problematic Area for Research

At the very least, it can be said that this research encountered resistance as well as a lack of communication and cooperation. While a number of Paediatricians gave freely of their time, it was apparent from the style and content of some of the survey returns that they were underlining the fact that they did not wish to cooperate. Again, only guarded qualified hypotheses, as to why this should be the case, are offered here. There may have been particular difficulties associated with the connotations of 'Munchausen' and intellectual associations with then current high-profile disciplinary cases, being reported in the media. While willing to notify cases, some Paediatricians declined follow up. There may also have been issues in respect of perceived ownership of an area and professional boundaries in respect of cross-professional working.

Child Protection Services refused any involvement. A request to the Association of Directors of Social Services for permission to conduct a Scotland-wide survey (Appendix 4) among Social Services Departments was declined, as was a request to the Director of Social Services, in the writer's employing local authority. The reasons given on both counts related to existing work-load among departments.

A request to the Principal Reporter (Children's Hearing System) for confidential notification of cases was declined on the basis of their policy of not allowing access to information held in files about children, in spite of an initial enthusiasm to cooperate, given prior to the intensive media coverage. (Appendices 5/6).

There will be a spectrum of legitimate reasons and concerns. A lack of confidence, particularly among doctors, in the ability of other professions to maintain confidentiality will rank highly, particularly given the now controversial nature of Msbp. One Consultant felt he could not participate further beyond recording one case, due to breaching his ethical code.

An examination of some of the research evaluating response rates and professional cooperation by doctors with surveys indicates that low response rates are typical (Van Geest et al 2007). Sent (1987) earlier identified low return rates when the salience to the recipient is low. It is suspected that in an era of electronic communication, mail-drops may appear anachronistic, although the Social Services Survey was intended to be via e-mail.

CHAPTER 7

Recommendations

The literature review has outlined emerging research interests and has described core developmental areas in professional practice. Eminson and Jureidini (2003) have drawn attention to the need to better understand the effects of maternal somatisation behaviour and obstetric history in the aetiology of Msbp: while Eminson and Postlethwaite (2000) have highlighted areas in current paediatric practice, which potentially engender Msbp. They stress the importance of '*good enough doctors*' with skills not only in arriving at clinical judgements but also in establishing effective communication with parents about what they describe as '*the nature and management*' of the difficulties, which '*they are presenting in a child*'.

From the research carried out here, a number of key difficulties in working in this area of child abuse were emphasised or emerged and are reflected in the Recommendations under specific headings. These reflect long-term and short-term aims with inherently varying degrees of attainability.

Use and Understanding of Terminology

This continues to provide difficulties and many *spectrum* cases demonstrably do not match the criteria for Munchausen Syndrome by Proxy, Fabricated Disorder by Proxy or Fabricated or Induced Illness but may nonetheless be harmful to children. Confusion as to terminology, however, should not get in the way of identifying and calling attention to acts of child abuse irrespective of the context, in which they occur. Abuse, afterall, is quantifiable in terms of its effects on a child. In terms of describing medical child abuse, terminology, however, does continue to provide its characteristic confusion. Fish et al (2005) express the same opinion. They state:

> *Fabricated or Induced Illness by carers previously known as Munchausen Syndrome by Proxy is not a condition, psychiatric disorder or diagnosis that a parent or carer has. Fabricated or Induced Illness by carers is what a parent or carer 'does' to a child.*

and,

Child protection workers do not need to make claims about the mental capacity or intention of the parents in order to demonstrate negative child outcomes.

There is some evidence, at least, that this is being recognised in court judgements. In Australia, the Supreme Court of Queensland, Court of Criminal Appeal, found that Munchausen Syndrome by Proxy was not a recognised medical condition, syndrome or disorder and, as a result, placed no value in expert testimony as to whether a person suffered from it (In Fish et al 2005). The Queensland Judgement has been adopted into English Law: A County Council v A Mother and A Father in respect of XYZ children, 18th January, 2005. (Case number WR03C00142). Mr. Justice Ryder stated that:

'The terms Munchausen Syndrome by Proxy' and 'Factitious (and Induced) Illness (by Proxy) are child protection labels that are merely descriptions of a range of behaviours, not a paediatric, psychiatric or psychological disease that is identifiable. The terms do not relate to an organised or universally recognised body of knowledge or experience that has identified a medical disease and there are no internationally accepted medical criteria for the use of either label'.

With respect to the assessment of risk he states:

'... the context and assessments can provide an insight into the degree of risk that a child may face and the court is likely to be assisted as to that aspect by psychiatric and/or psychological expert evidence'

and, finally:

'... evidence as to the existence of Msbp or F.I.I. in any individual case is as likely to be evidence more of a propensity which would be inadmissible at the fact-finding stage. For my part, I would consign the label MSBP to the history books and however useful FII may apparently be to the child protection practitioner, I would caution against its use other than as a factual description of a series of incidents or behaviours that should then be accurately set out (and even then only in the hands of the Paediatrician or Psychiatrist/Psychologist)'. (Wikipedia. Fabricated or Induced Illness 2007).

Purdis (2004), who has proposed a list of principles representing *good practice* when presenting cases before a court, has likewise cautioned against opinions on human behaviour unless founded on accepted scientific research.

Recent RCPCH Guidance (2002) has provided some clarification in its recommendation of Fabricated or Induced Illness by Carers, as the new terminology, thereby obviating the connotations of 'Munchausen Syndrome' and provides a clear focus on acts of child abuse. However, that there remains an extant psychiatric diagnostic classification for the perpetrator, recognised in Factitious Disorder by Proxy (DSM IV T-R 2000) continues to provide complications in terms of attribution and of definition, *by motivation.*

A radical solution would be one, which retained the diagnostic label Factitious Disorder as *a psychiatric conclusion*, in adults, while abandoning entirely, the '*by proxy*' component, which clearly relates to child abuse, identified in Appendix B (criteria sets and axes provided for further research). To this extent, Munchausen Syndrome by Proxy is better accommodated in the ICD 10 (WHO 1992) classification system, which describes the health status of the child, while also providing a coding under '*maltreatment syndromes*' (Eminson and Postlethwait 2000). Whether any classification is required is debatable.

From the perspective of day-to-day working in child protection, it would seem appropriate to retain *Fabricated or Induced Illness by Carers* in reference to cases physically evidenced as such but to apply *Factitious* as a prefix, more generally, in examples where there is parental abnormal illness behaviour in respect of presenting children persistently and unnecessarily to doctors: hence, by way of examples, Factitious Epilepsy, Factitious Allergies etc. This is broadly in keeping with the recommendations made earlier by Fisher and Mitchell (1995). This makes clear that there is no organic basis for the presentations of the child and permits decisions as to whether maternal behaviour is abusive to the child, to be informed by the concept of thresholds of *Significant Harm.*

This approach, absent the need to draw inferences about maternal functioning, is likely to improve understanding of this realm of abuse and of the tasks required to maintain children's safety by promoting a rubric, which better describes a form of child abuse. It also provides a more structured and focused context, in which to articulate professional concerns, some of which may not emanate from medical sources. Over-presentation of children to a range of professionals for assessment (commonly for Autism and Behavioural *Disorders*, notably A.D.H.D.) would be widely recognised by developmental and child psychologists, as representing manifestations of factitious presentations although perhaps not by Doctors, who have resisted *expansion* of the use of the terminology and recognition of abnormal parental behaviour in presenting children to other professionals (Jones 1996). There has been recognition of this increasing trend in the Mbps literature (Schreier 1996).

Risk Assessment

In order to develop early intervention strategies, it is important to identify factors which *may* lead to child abuse, although in isolation and even in clusters, they themselves are not predictive, as argued above. Understanding the temporal association of factors in conjunction with the significance of individual characteristics provides a broader basis for understanding the origins and, indeed, proliferation of all forms of child abuse. With this in mind, assessment of maternal behaviour and the current and future risk, which this may pose to a child or other children in the home, should optionally fall within the professional remit of *both* Psychiatry and Child Protection Services to determine.

Promoting Shared Professional Understanding and Practice

This is an adjunct to issues and complications in respect of the *use and understanding of terminology* and is a pre-requisite to effective collaborative practice in child protection work. It is inevitable that there are better outcomes for children, as victims of abuse, if everyone is working towards a standard of shared understanding, guiding good professional practice.

The RCPCH Guidance (2002) recognises, in its recommendations, the importance of collaborative work with child protection agencies and has delineated key areas of professional training and '*good practice*' for doctors. It is to be anticipated that other professions and agencies will have specific training needs, in this area.

At the core of good practice, among all professions, lies skilled history-taking not only in respect of the course of an illness or symptoms but in respect of family history as a way in to assessing family functioning and '*the meaning*' of the child within the family, as discussed above. The development of strategies to engender skills in information gathering, leading to the generation of hypotheses as to why a child is being presented to a *professional* setting are essential professional skills and those most likely to protect children.

It is recommended here that in order to promote and facilitate collaborative '*inter-agency*' working and practices, all professionals, directly involved in child protection case management, who are likely to encounter Msbp, and indeed, other manifestations of child abuse, should undergo mandatory *joint* community-based inter-agency training.

Recommended Core Areas of Knowledge for Inter-Agency Training

- aboveall, understanding Msbp as child abuse
- understanding terminology
- models of child abuse and maternal family functioning
- understanding *the spectrum* of parental illness behaviour
- harmful parental *(illness)* behaviour defined within developmental '*domains*' and concepts of '*Significant Harm*'
- Professional tasks within a process of inter-professional collaboration and responsibility to child protection work
- Risk Assessment
- Management and Intervention Strategies

Predicating all of this is an emphasis, which recognises Msbp as child abuse and, as such, that it can be articulated within developmental domains and concepts of *Significant Harm*. However, a lack of professional surety and confidence about this area of child abuse, in particular in respect of what might broadly be referred to as '*spectrum*' cases, where evidence as to whether parental behaviour might be crossing the threshold into *Significant Harm*, gets in the way of reporting cases for further investigation by Child Protection Services. This is writ large for non-medical professionals, working with children, who encounter repetitive factitious presentations and who struggle to find contextual frameworks for describing parental behaviour as abusive. As emphasised, here, this exists within the concept of *Significant Harm*. The mechanism also exists for reporting concern or suspicion of abuse, which empowers professionals to air concerns with child support/protection agencies.

Emphasising the Role of General Practitioners

G.Ps provide primary health care and are central in managing Msbp cases at all stages. The literature indicates that this group of medical practitioners may generally have particular training needs in identifying and managing cases, in which *maladaptive* parental behaviour, manifesting in the over-presentation of children with factitious complaints, may be harmful. The principles of case management and case control fall within the remit of the professional training for this particular branch of medicine: however, Msbp requires a specific management approach and structure, if risk is first to be recognised and later managed and contained. The first step lies in taking ownership.

As an adjunct to *Promoting Shared Understanding and Practice*, it is recommended that G.P. practices nominate one or more partners as having designated responsibility for child protection work. This is in keeping with recognised good practice under the Children (Scotland) Act 1995 and is in line with other services and professional groups working with children. *Responsibility*, in this context relates to accessing appropriate training for colleagues, implementing Local Authority Child Protection Procedures when required, and developing practice procedures. *Recognising* child

protection work as an area of professional responsibility and *taking ownership* is a necessary first step. Currently, child protection work is generally delegated to Health Visitors and Public Health Nurses attached to individual practices. This represents sub-optimal direct involvement by G.Ps themselves.

Future Research and Training

Surveys of key child protection services were attempted but were not given the appropriate permissions to proceed, as described above. Research aimed at describing *the spectrum of harm* to children, from this form of child abuse, is essential in widening understanding of factitious presentations as well as in shaping prevention and early intervention strategies. Inter-agency collaboration is likewise anticipated, being in keeping with the spirit of '*Getting It Right For Every Child*' (Scottish Executive 2005), which places a duty on services to work together in a spirit of cooperation.

The research carried out here demonstrated a range of harmful parental illness behaviours. Further research is required akin to that proposed here (Appendix 4) to illuminate this area further and to have it recognised and spotlighted through professional training. Given the comparative rarity of *factitious spectrum cases*, skills and knowledge-based deficits might be anticipated across all child protection services, engendering an understandable lack of confidence and reticence in working in this area. The mechanisms are in place, through professional development programmes and in Local Authority Services, through the Child Protection Committees for meeting training needs.

Flagging Concerns

Systems currently in development within the National Health Service (for example, e-health), will at some point in the future provide tiered access to a common personal record, accessible to all child protection services, password protected. This is in the early stages of refinement. An up and running system exists, however, which can provide information about whether there are concerns about a particular child and whether the child is on '*the protection register*' and the number of presentations to

Accident and Emergency Departments. It is recommended that *confirmed* and *suspicious* cases of Fabricated or Induced Illness or of '*factitious presentations*' be specifically flagged and detailed and accessible to Doctors and Social Services Departments. Other professionals involved in child protection work might be informed on a need-to-know basis.

Closing Thoughts

The title of this thesis draws attention to the importance of understanding Munchausen Syndrome by Proxy as child abuse and has recommended changes to terminology, which support a contextual explanatory framework beyond that purely based around maternal functioning. Historically, this problematic area has provided a smokescreen, clouding understanding and providing an intellectual diversion from acts of child abuse, unique to Msbp. It is unlikely that Paediatricians will be dissuaded from reporting what they see as medical evidence of abuse, although demonstrating to child protection agencies that *carer* behaviour is *abusive* is a different matter, lying at the nub of Msbp. The pre-requisite set of concepts is that women do harm children. This has provided intellectual and psychological challenges, which make explanations embedded in disorder-models more palatable and comfortable but inherently problematic.

The contentious nature of Msbp has, as a result, provided the popular press with *causes célèbres* and with opportunities to declare open season on professionals, acting in good faith to protect children. There is something of an inevitability given that Msbp is variously understood ambiguously as medical child abuse, as an extrapolation from a pre-existing adult disorder and, importantly, as an area of child abuse over which Doctors *have ownership*. Historical perceptions (albeit eroded) of the power and status of the profession augment this.

Suggestions have been made here for scaffolding the child protection process in this area. Currently, procedures exist in the RCPCH Guidance (2002), in Local Authority Child Protection procedures (Children (Scotland) Act 1995) as well as being in keeping with the current draft document '*Getting It Right For Every Child*' (Scottish Parliament Bill (Draft) 2006). This latter set of proposals lies at the heart of public

services reforms and aims to create an integrated, coordinated and seamless approach to service delivery to children. There is nothing, however, which describes how this process will come about, particularly in complex areas of child abuse.

Professionals working in England and Wales have the benefit of guidance provided by '*Safeguarding Children in whom Illness is Fabricated or Induced*' produced within the context of '*Working Together To Safeguard Children*' and the '*Framework for the Assessment of Children in Need and Their Families*' (Department of Health, 2000 and National Assembly from Wales 2001). In its own words, this sets out *frameworks for services working together to assess children's needs in order to promote and safeguard their welfare* (P5). This document provides valuable explanatory background to F.I.I. and how to manage cases through assessment and the child protection system. It appropriately outlines the need for multi-agency/professional coordinated involvement. There is, however, no Scottish equivalent, which is a short-coming identified here. Relevant '*agencies*' are more likely to work more confidently and effectively for children if they understand what they are doing and have a clear lead on the core tasks required of them and other professionals. Misunderstanding of Msbp at all levels and echelons, including the criminal justice systems, provide potentially very poor outcomes for children.

Demystifying and removing much of the burden of understanding Msbp through accessing current research and approaches to terminology and definition is a prerequisite to dispelling the misapprehension, fear and reticence, which is a reality of work in this area. This has been highlighted as a significant consideration here.

The unwillingness to cooperate with the research, by key child protection services in particular, is unlikely to be wholly accounted for by anticipated work-load stress, since it was clearly on a voluntary basis. Equally clear was professional demarcation: one Paediatrician, thankfully wrongly, anticipated this research would not be well received among colleagues: '*You will not get cases*'. Characteristically in research, it was, as it turned out, variously well received.

The issue of employer understanding of the field, liability and vicarious responsibility loomed large here and has been raised by Paediatricians, themselves, particularly in

the fall-out from recent high profile disciplinary cases. That no support was provided by the writer's employing authority, to this research, made clear a lack of understanding and recognition of the salience of the topic and what this might contribute to increasing knowledge of manifestations of abuse of children. This was further demonstrated in a restriction bordering on a veto, which meant that a paper, providing a case-notification of what was believed to be an example of Factitious Asperger Syndrome, in an adolescent boy, could not be submitted for consideration for publication. Some of the content of the paper is referenced here.

The possibility of litigation and compensation might *focus the mind* and perhaps Local Authorities, accountable for how public money is spent, have a legitimate right to be concerned about any potential compensation claims: however, this becomes problematic when the litigation mind-set interferes with the day-to-day business of child protection work and the identification of risk to children from parental behaviour. This is a difficult area of practice often relying heavily on professional judgements in respect of thresholds of harm to children, as discussed here, throughout. At the risk of sounding glib, competent professionals require the authority and backing of employers and relevant professional bodies to enable them to do this work and to protect children.

The common thread woven through the Recommendations, here, identifies the need for education and training and more open-ness and discourse bringing *Msbp as child abuse* and the spectrum of abnormal adult behaviour in providing damaging experiences to their children, out of the shadows of ignorance, misunderstanding and fear.

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APPENDIX 1/2

Summary of Cases of Fabricated or Induced Illness by Physical Intrusiveness Category

The table provides details of 313 cases classified into Physical Intrusiveness categories. Additionally the presenting symptoms and/or signs are summarised. The first five references identify major series up to the date of preparation of this review, which are not included in the table. The cases in these references should be seen as complementing the details presented in the table. References 6 to 162 are the sources from which the details of the 313 cases in the table were extracted.

PIC	Number of index cases	Details of index fabrication
1	44(14%)	abdominal pain [6,7], apnoea [6, 8,9], asthma [10-12], ataxia [6], chest pain [13], choking [14], conduct disorder [10], deafness [15], falling [16], feeding difficulty [17], food intolerance [6, 18, 19], headaches [10,20], joint pains [10], lethargy [21], multiple sclerosis [20], multiple [22], polyuria/polydipsia [14], pyrexia [20], recurrent infections [23], respiratory problems [6], seizures [6, 23-27], swallowed coins [28], sweating [6], thyroid disease [20], vomiting and/or diarrhoea [6, 29].
1	23(7%)*	bleeding diathisis [30], bleeding from mouth and/or ears [31-33], CSF ottorhoea [34], cystic fibrosis [35], diabetes insipidus [6], fever [6], glycosuria [32, 34-38], haematemesis and/or malaena [39-41], haematuria [6, 42-46], hyperkalaemia [47], jaundice [16].
2	14 (4.5%)	behaviour problems [6], failure to thrive [6, 48], feeding problems [6], generalised oedema [48], rickets [48].
3	62 (20%)	central line complications other than infection [6, 49,50], central lines recurrent sepsis due to interference with [6,24, 51-62], dermatitis artefacta [25,12, 63-66], gastrointestinal pseudobstruction [67-69], injury to mouth and/or ears [24, 70-76], other [6, 16, 39, 49, 70, 77-81], recurrent infections [6, 54, 56, 82-85], renal stones [86-88].
4	41 (13%)	diuretics [89,90], emetics/laxatives [6,9, 16, 91-107], fruit juice [9, 104]
5	90 (29%)	anticoagulants [108-111], antidepressants [112-114], arsenic [17, 115], barbiturates [70, 90,112, 116-118], bleach [119, 120], chloral [26,121,122], diazepam [119], hypernatraemia [6, 43, 90,123-127], hyponatraemia [128, 129], insulin alone [130-135], insulin plus another drug [136,137], miscellaneous [6, 9, 12, 16, 90, 116, 120, 138-144], multiple [23, 70, 108, 116, 138], oral hypoglycaemic [90], pepper [119, 145,146], phenothiazines [32, 147-149].
6	39 (12.5%)	Apnoea/seizures/near miss cot death/cardiac arrest [9, 17, 29, 72, 98, 103, 112, 120, 138, 150-162].
Total	313	

Table - Overview of cases

* Fabrication plus the falsification of specimens or charts

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Summary of Cases of Fabricated or Induced Illness by Physical Intrusiveness Category

The table provides details of 313 cases classified into Physical Intrusiveness categories. Additionally the presenting symptoms and/or signs are summarised. The first five references identify major series up to the date of preparation of this review, which are not included in the table. The cases in these references should be seen as complementing the details presented in the table. References 6 to 162 are the sources from which the details of the 313 cases in the table were extracted.

PIC	Number of index cases	Details of index fabrication
1	44(14%)	abdominal pain [6,7], apnoea [6, 8,9], asthma [10-12], ataxia [6], chest pain [13], choking [14], conduct disorder [10], deafness [15], falling [16], feeding difficulty [17], food intolerance [6, 18, 19], headaches [10,20], joint pains [10], lethargy [21], multiple sclerosis [20], multiple [22], polyuria/polydipsia [14], pyrexia [20], recurrent infections [23], respiratory problems [6], seizures [6, 23-27], swallowed coins [28], sweating [6], thyroid disease [20], vomiting and/or diarrhoea [6, 29].
1	23(7%)*	bleeding diathisis [30], bleeding from mouth and/or ears [31-33], CSF ottorhoea [34], cystic fibrosis [35], diabetes insipidus [6], fever [6], glycosuria [32, 34-38], haematemesis and/or malaena [39-41], haematuria [6, 42-46], hyperkalaemia [47], jaundice [16].
2	14 (4.5%)	behaviour problems [6], failure to thrive [6, 48], feeding problems [6], generalised oedema [48], rickets [48].
3	62 (20%)	central line complications other than infection [6, 49,50], central lines recurrent sepsis due to interference with [6,24, 51-62], dermatitis artefacta [25,12, 63-66], gastrointestinal pseudobstruction [67-69], injury to mouth and/or ears [24, 70-76], other [6, 16, 39, 49, 70, 77-81], recurrent infections [6, 54, 56, 82-85], renal stones [86-88].
4	41 (13%)	diuretics [89,90], emetics/laxatives [6,9, 16, 91-107], fruit juice [9, 104]
5	90 (29%)	anticoagulants [108-111], antidepressants [112-114], arsenic [17, 115], barbiturates [70, 90,112, 116-118], bleach [119, 120], chloral [26,121,122], diazepam [119], hypernatraemia [6, 43, 90,123-127], hyponatraemia [128, 129], insulin alone [130-135], insulin plus another drug [136,137], miscellaneous [6, 9, 12, 16, 90, 116, 120, 138-144], multiple [23, 70, 108, 116, 138], oral hypoglycaemic [90], pepper [119, 145,146], phenothiazines [32, 147-149].
6	39 (12.5%)	Apnoea/seizures/near miss cot death/cardiac arrest [9, 17, 29, 72, 98, 103, 112, 120, 138, 150-162].
Total	313	

Table - Overview of cases

* Fabrication plus the falsification of specimens or charts

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RJ Postlethwaite
February 2003

APPENDIX 3

Dear Doctor

I am currently carrying out Phd research in the area of Munchausen Sydrome by Proxy (Fabricated or Induced Illness) within the Forensic Medicine Section, Division of Pathology, University of Edinburgh. As part of this research I am surveying cases in Scotland, initially among paediatricians. I will ask you to note any cases that you have had professional experience of across the period January 2004 to January 2005. Please do not record any cases, with which you have not had direct clinical contact: this is very important. Please record cases where Msbp has either been formally recognised(diagnosed) or suspected, to the extent of being discussed with other agencies, even if only informally.

I would be most grateful if you could spare a few minutes of your time to complete the attached questionnaire and to return it to me in the pre-paid envelope.

With your permission I may contact you again to seek further information, if appropriate.

With Much Thanks

Yours Sincerely

Essie Tough C.Psychol., M.A. M.Ed., M.Sc.
Chartered Psychologist

Dear Doctor

Munchausen Syndrome by Proxy Survey

Thank you for returning my previous questionnaire. I am extremely interested in the case(s) which you recorded, and wondered if you could spare me some time to complete the attached questionnaire as the next stage of the survey. I would envisage the completion of the survey taking no more of your time than approximately 20 minutes.

However, should you not wish to continue, I would like to take this opportunity to thank you for your co-operation to date.

Yours Sincerely

Munchausen Syndrome by Proxy (Fabricated or Induced Illness) is a form of child abuse, in which medical conditions are fabricated, falsified and exaggerated in a child by an adult carer. Typically, a child will be over presented to medical services and may be subjected to an extensive range of medical tests and interventions. The child may have a pre-existing condition. The motivation and behaviour of the presenting adult may have raised professional concern.

Number of Cases Compatible With The Above Description Jan 04-Jan05

Number of Cases	Confirmed	Suspected
☐	☐	☐

SURVEY ___

MUNCHAUSEN SYNROME BY PROXY(MsbP) PAEDIATRICIANS SURVEY

MBP

Munchausen Syndrome by Proxy (Fabricated or Induced Illness) is a form of child abuse, in which medical conditions are fabricated, falsified and exaggerated in a child by an adult carer. Typically, a child will be over presented to medical services and may be subjected to an extensive range of medical tests and interventions. The child may have a pre-existing condition. The motivation and behaviour of the presenting adult may have raised professional concern.

Please note that the information which you provide should pertain to the period January 2004-2005
Please provide the following details.

Case Details

Child's Initials ☐

Age on presentation ☐

Gender
M-male, F-female) ☐

Number of Siblings ☐ **Alive** ☐ **Deceased** ☐

Geographical location of the family _____

Perpetrator Characteristics

Relationship to child _____

	<16	16-20	21-30	31-40	41+
Age Group	☐	☐	☐	☐	☐

Responsibility Accepted ☐ Denied ☐

Current Status (2005 to Present).

Case Status

On-Going ☐ Discharged ☐ Unknown ☐

Health Status of Child *(brief description)*

_____

_____

Place of Residence of Child

Home ☐ In Care ☐

Within the Family ☐ Other, *please specify* _____

Contact with Perpetrator

Yes ☐ No ☐

Family Dynamics

Main Carers

N-natural parent
ST/P-step parent

	N	ST/P	Occupation
Mother	☐	☐	_____
Father	☐	☐	_____
Other	_____		_____

Case History

	Suspected	Diagnosed	Discounted
MsbP	☐	☐	☐
By	_____	_____	_____

Presenting Condition (s) _____

Referred by _____

Other Services Involved

Police	Social Work	Other Medical Professionals
☐	☐	☐

Please Specify _____

Were you satisfied with the involvement of other services? *Explain briefly*

Is there anything that you have learned from the handling of this case, that you would share with colleagues?

APPENDIX 4

Sophie Mills
Administrator (Research)
Association of Directors of Social Work
Edinburgh

Dear Sophie

Department of Social Work Services Survey/Ph.d Research

Thank you for agreeing to circulate my survey. When we last spoke, you were unwell. I hope you have recovered.

When this material reaches you, Sophie, it will have cleared the university department supervising the research. The results will only be used for research purposes and will only be written up, as such. Strict standards of confidentiality will be maintained throughout. What follows is a basic rubric:

- Survey circulated by e-mail to all social services departments in Scotland, with the covering letter.
- All returns (including nils) to E.M.B.Tough@sms.ed.ac.uk or in printed format to me, in the Forensic Medicine Department, as detailed on the letter-head.
- I am wondering if all returns could be made by 14 February 2007 or is this unrealistic?

I look forward to your advice on any of the above based on your experience of returns. If you think I should amend anything, please telephone me during the day-time on 01236 731041.

Yours sincerely and again with many thanks for your help.

Essie M B Tough
Chartered Psychologist

This is a survey of all Social Services Departments in Scotland. The questions relate to parental behaviour in respect of seeking unnecessary health care for a dependant child or children, under 16. Please only record cases active within the last three years.

Dear Colleagues

I would be very grateful for a few minutes of your time to complete this survey questionnaire.

- This survey is being carried out under the auspices of the Division of Pathology (Forensic Medicine), University of Edinburgh.
- The results will be written up as part of my Ph.d research.
- Strictest confidentiality will be maintained and neither the individuals responding to this survey nor the cases described will be identifiable in any way.

I am asking you to provide me with information about your experience in this area of child care work. If you are recording no cases, please indicate nil on the first sheet and complete question 12 and the questions *about you* at the end.

Please accept my sincere thanks, in advance, for your time and cooperation.

Essie M B Tough
MA (Hons) M.ed., M.Sc.,CPsychol.
Chartered Psychologist

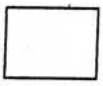
Enc

I am asking you about your individual case experience within the last three years of cases fitting the description, below. Please only record cases in which the child was 16 or below at the time.

I am asking you to record cases where you had concern about parental behaviour in terms of excessive and unnecessary presentations of a dependant child to health care services, to the extent that this led you to consider whether this constituted significant harm to the child.

Exaggerated or invented symptoms, doing the rounds of Doctors, medicating the child or falsifying medical histories may be factors.

Please record numbers of cases:
each affected child in a family counts as one.



Looking at each case individually, can you provide the information below. Some demographic information is sought to differentiate cases when collating the results. Comment further in space provided, below, if required				
Complete in respect of each child noted	Case One	Case Two	Case Three	Case Four
1. In which Region does or did the child live at the time of the presentation?				
2. Sex of child	M ☐ F ☐	☐ ☐	☐ ☐	☐ ☐
3. Age on first presentation				
4. Age now at 1 January 2007				
5. Relationship to child of person presenting child	Mother ☐ Father ☐ Other ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
6. Have there been concerns about other children in the family in respect of this behaviour. Please explain below. (Note if siblings etc.).	Yes ☐ No ☐ Nos ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
7. Child is or was on child protection register Referred into Children's Hearing System Case referred to Police	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐
8. Did the child have a diagnosed medical condition ? If yes, please provide details below.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Pre-existing conditions Case 1				
Case 2				
Case 3				
Case 4				
Further comment or Additional Information about any of the above:				

	Case One	Case Two	Case Three	Case Four
9. Can you rank the severity of the parental behaviour in terms of outcomes for the child				
• Most severe. Actual physical harm e.g. poisoning, suffocation, death	☐ 1	☐ 1	☐ 1	☐ 1
• Severe. Fabrication of results, tampering with tests, hospital equipment etc.	☐ 2	☐ 2	☐ 2	☐ 2
• Moderate. False invented history, not actively causing symptoms.	☐ 3	☐ 3	☐ 3	☐ 3
• Least Severe. Exaggeration of symptoms only.	☐ 4	☐ 4	☐ 4	☐ 4

10. Can you provide a very brief synopsis of the case history, below.

Case 1

Case 2

Case 3

Case 4

Further comment or Additional Information about any of the above:

11. Briefly describe the outcomes for the child in terms of current health status as well as general functioning at home and school, if known.
Case 1
Case 2
Case 3
Case 4

12. In order to gain information about your knowledge and experience in this area of child care and protection can you answer the questions below indicating your level of agreement on the 1-6 scale.

1. I am confident about what would constitute *significant harm* in the context of children being unnecessarily presented to health care services	Strongly Agree → Strongly Disagree 1 ------ 2 ------ 3 ------ 4 ----- 5 ------- 6
2. It is difficult to differentiate between parents, who are generally concerned about a child and those deliberately misleading professionals about their child's health status.	Strongly Agree → Strongly Disagree 1 ------ 2 ------ 3 ------ 4 ----- 5 ------- 6

3. I am confident working in this area of child care.	Strongly Agree → Strongly Disagree 1 ------ 2 ------ 3 ------ 4 ----- 5 ------- 6

Use the space below to comment further should you wish to do so on any aspect of the cases noted or about this particular area of work.

Finally, thank you most sincerely for your invaluable help and cooperation. Please complete the final section of the survey below and follow the instruction for return.

Job Title .....

Geographical Area .....

Years in Practice .....

Footnote The Advice of Dr Simon Denny of Auckland, New Zealand (private correspondence) is acknowledged here.

- The work of Watson, Eminson and Coupe 1999 is acknowledged.

APPENDIX 5

Psychological Service
Kyle Road
Kildrum
CUMBERNAULD
G67 2DN

ET/DH

14 March 2007

Local Authority Reporter
North Lanarkshire
70 North Road
Bellshill
GLASGOW
ML4 1EN

Dear

Research: Fabricated and Induced Illness

As you know from our previous conversations, I am researching the above area at Edinburgh University (Ph.d part-time within the Forensic Medicine Department. I am currently trying to gather as much information as I can about not only the number of confirmed or suspected cases in Scotland but also about children, who may have been the subject of CPOS or on the CP Register due to concerns above over-presentation to medical services. I am wondering if you might have ideas as to how I might access this information – if at all available – within your service. Clearly, any information provided would be dealt with appropriately, in terms of confidentiality and anonymity as well as the use made of it, which would be for Ph.d research purposes only, with limited university leadership. Any information provided by your service would, I am sure dove-tail with data from other services. Information from S.C.R.A would provide a most valuable component to the research.

I look forward to your view.

Yours sincerely

Essie M B Tough
Chartered Psychologist

APPENDIX 6

SCOTTISH
CHILDREN'S REPORTER
ADMINISTRATION

2 April 2007

Principal Reporter
Margaret Cox

If calling please ask for:

Telephone:
01786 459576

Ms Essie Tough
Psychological Service
Kyle Road
Kildrum
Cumbernauld
G67 2DN

Dear Ms Tough

Thank you for your letter of 14 March 2006 that you sent to regarding your research on fabricated and induced illness.

You asked for data on the number of known cases and in particular "children who have been subject to Child Protection Orders due to concerns about over-presentation to medical services".

Unfortunately this is not information that SCRA holds centrally. Consequently the only way of obtaining this data would be to go through all the case files of children who have been subject to a Child Protection Order, which, I am sure you can understand, would be an extremely time consuming task and we need to consider the burden placed on staff in local offices in extracting information. Furthermore, it is important for you to know that SCRA does not provide information on individual cases without informed consent and we do not allow non-SCRA staff access to our files.

I'm sorry that we could not be of help at this time but I wish you all the best in your research.

Yours sincerely

Information and Research Manager